MAKING MEANING OF MEDIA MESSAGES: HOW WOMEN INTERACT WITH THE MESSAGES IN DIRECT-TO-CONSUMER ANTIDEPRESSANT ADVERTISEMENTS

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ABSTRACT

Television is a medium through which dominant cultural ideologies about health and illness circulate. Direct-to-consumer (DTC) drug advertisements, such as those for antidepressants, communicate a distinct image of illness and intervention, and have the potential to shape how we understand these experiences. Though there has been much debate on whether such advertising should be permitted, as well as explorations of their impact, there is an absence of qualitative research on how the public interacts with and makes meaning of these ads. The purpose of this study was to explore the ways in which the public interacts with the messages related to depression and its treatment in DTC antidepressant ads shown on television. Six semi-structured focus groups of 1-2 hours, with 4-6 female participants per group were conducted. Within each group, 2-3 DTC antidepressant ads were viewed, followed by a discussion after each viewing. Focusing on the function of language, discourse analysis was the methodology chosen to explore how the women took up and negotiated the messages within the ads. I show how the women problematized the presentation of depression and its treatment within the ads, often positioning the ads as falling short due to various oversimplifications of depression and treatment. More specifically, they evidenced a reclaiming of normal and depression, as well as a caution in engaging with and staking claims to these categories. This research provides a more in-depth understanding as to how these ads can impact women, who are over-represented in those who are prescribed antidepressants, and how women can take on and challenge the messages in these ads.

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LIST OF ABBREVIATIONS

Direct-to-consumer ……..… DTC

CHAPTER 1
INTRODUCTION

The ways in which individuals come to understand mental health and illness are embedded within cultural contexts that structure understandings of experience (Kirmayer, 2007; Obeyesekere, 1985). Various cultural media, such as on-line and television drug advertisements, have the potential to communicate and reinforce dominant understandings of mental health and illness (e.g., individualized, gendered, and decontextualized conceptions that often focus on biological notions of depression) thereby influencing both these broader cultural contexts and the ways in which individuals come to understand intervention (American Psychological Association, 2010; An, Jin, & Brown, 2009; Gardner, 2003; Kilbourne, 2000; Kleinman & Cohen, 1991; Rubin, 2004). Antidepressant advertisements and the associated depictions of depression are one example of this interplay. The purpose of this research is to analyze the ways in which individuals interact with conceptualizations of depression in antidepressant advertisements.

Critiques of antidepressant advertisements have argued that, within these advertisements, the complexities and uncertainties related to depression are ignored through a self-serving focus on a medicalized conception of depression, and through the positioning of depression as an individual problem with an individualized solution (Kleinman & Cohen, 1991; Rubin, 2004; Stepnisky, 2007). Similarly, it is argued that this distinctly intrapersonal conception of depression often ignores the various socio-contextual factors that are important in understanding experiences of distress (Astbury, 2006; Belle & Doucet, 2003; Varcoe, 2009). Research has shown that individuals both take up and negotiate dominant medicalized conceptions of depression in various ways, and that there are nuances and complexities in how individuals talk about depression (Lafrance, 2009; Lafrance & Stoppard, 2006; McMullen & Sigurdson, 2013; Stoppard & Gammell, 2003). Though current research has explored the potential impact of antidepressant advertisements on the public (Bell, Taylor, & Kravitz, 2010), there has been a dearth of research on how individuals actually understand the messages of these advertisements, and how they interact with, negotiate, shape and/or take up discourses related to depression in their conversations on the topic. This research seeks to redress this gap in relation to how the public interacts with and makes meaning of the messages in DTC antidepressant ads. Based on evidence, it would appear that the public is not passive consumers of health messages (Lock,

2012), and therefore I would expect the public not to be passive when consuming the messages in DTC antidepressant ads, but engage with them in a complex way. This potential complexity would be important to consider when discussing these types of ads, including debating policy surrounding them.

This introductory chapter consists of a review of relevant literature pertaining to this research project, beginning with a brief discussion of mental health and illness, with an emphasis on the ways in which conceptions of mental health and illness in general are shaped by cultural context, including time and place. From there, I discuss conceptions of depression specifically, including dominant Western conceptions of depression and its treatment as well as controversies surrounding these dominant conceptions. This conceptual grounding will lead into a discussion of the ways in which the public, with a focus on women specifically, make meaning of and talk about depression and its treatment, in light of these dominant conceptions. Media may be seen as prominent means through which dominant cultural meanings are communicated and reified (American Psychological Association, 2010; Kilbourne, 2000; Kleinman & Cohen, 1991; Rubin, 2004), and, for this reason, I then move on to a discussion of antidepressant advertisements as a potential medium of cultural communication in relation to depression. Specifically, I look at how conceptions of health and illness in general, and depression specifically, are constructed in these advertisements, the messages they communicate, and the potential impact these messages might have on the public, including their potential impact on how depression is broadly understood. This chapter will conclude with a presentation of the purpose of this research project. Finally, this introductory discussion will lead into the second chapter, where I present the proposed methodology for the current study.

1.1 Conceptions of Mental Health and Illness

Some scholars have hypothesised that what it means to be mentally healthy and mentally ill, as well as what falls within the domain of psychiatric and psychological expertise, varies across time and place and is shaped by the sociocultural context within which the concepts are invoked (Fancher, 1995; Kirmayer, 2007; Obeyesekere, 1985). As such, individuals learn the meaning of, and how to perform mental health and illness, through various interactions with their sociocultural context (Kirmayer, 2007; Lemelson, Kirmayer, & Barad, 2008; Martin, 2009; Obeyesekere, 1985). For example, in the current Western cultural contexts, if an individual says that she or he is ‘blue,’ ‘feeling down,’ ‘feeling depressed,’ and/or seems to ruminate on sadness

and hardship, it is generally understood that the individual is experiencing distress and psychological suffering. Contrarily, in a context in which Buddhist values dominate, a focus on hardship and sadness can be viewed as something highly valued and as a natural experience (Obeyesekere, 1985). As such, due to differing cultural understandings, a similar experience might either be positioned as a mental health issue in need of treatment, or as something not indicative of a mental illness, but rather as a valued or natural state or experience (Obeyesekere, 1985). As such, it has been argued that how we come to understand our own experiences, and express these experiences, are shaped by culture (Kirmayer, 2007; Lemelson et al., 2008; Martin, 2009; Obeyesekere, 1985). Individuals learn to communicate distress in ways that are validated within their specific sociocultural context; in addition, their sociocultural context shapes how they come to understand their own experiences (Lemelson et al., 2008; Martin, 2009; Obeyesekere, 1985). As such, it is evident that culture plays an integral part in mental health and illness.

Dominant cultural conceptions of self and ideal personhood are implicated in the construction of conceptions of mental health and illness (Kirmayer, 2007). For example, an egocentric conception of self dominates within the West, and, as such, conceptions of mental illness and treatment focus on the individual (Kirmayer, 2007; Martin, 2009; Stepnisky, 2007). Traits such as individualism, self-esteem, individual productivity, creativity, independence, and self-control are valued (Kirmayer, 2007; Martin, 2009; Stepnisky, 2007). Further, the full or partial absence of these traits is positioned as potentially pathological and in need of professional intervention (Kirmayer, 2007; Martin, 2009; Stepnisky, 2007). In contrast, in a context where a sociocentric conception of self dominates, i.e., one in which the self is defined more in relation to social relationships than through the individual, diminished mental health might be understood, experienced and expressed through troubled kinship or social relationships (Kirmayer, 2007). As such, it has been argued that not only are performances of mental health and illness shaped by the sociocultural context, but the signals that are deemed indicators of mental health and illness are also shaped by contextual factors (Kirmayer, 2007; Martin, 2009; Obeyesekere, 1985).

It has been argued that how mental health and illness are conceptualized shapes not only how individuals understand, interpret, and express their own experiences, but also how treatment is constructed and structured (Good & Good, 1986; Kirmayer, 2007). For example, if an egocentric conception of self dominates within a specific cultural context, mental health is likely

to be seen as an individual issue in need of an individual solution, such as through taking medication or individual therapy (Kirmayer, 2007; Stepnisky, 2007). If a sociocentric conception of self dominates, the problem is likely to be structured as implicating social and kinship relationships, and, as such, treatment might focus on these relationships or be more socially oriented (Kirmayer, 2007). For example, in a context within which illness is conceptualized as related to various kinship relations, such as being due to jealousy on the part of neighbours or troubled relations with a deceased family member, treatment might focus on these social issues, rather than being placed on the individual who is ill (Chapman, 2006). Further, in a context in which concepts of witchcraft and sorcery are used to conceptualize how social relations can result in illness, the individual might seek treatment from a prophet or herbalist, for example, who will address social concerns (Chapman, 2006). Though there is likely variation, an egocentric conception of self tends to dominate within Western cultural contexts (Kirmayer, 2007; Martin, 2009).

It could also be argued that this conception of depression and its treatment reflects a cultural focus on productivity - focus tends to be on alleviating the symptoms related to depression rather than on underlying personal and social conditions that might trigger or exacerbate depression (Martin, 2009). Some scholars go so far as to argue that mental illnesses, such as depression, do not 'exist' (Szasz, 1960; Vice, 1989). Specifically, it is argued that that which is labeled mental illness is simply normal variation in human experience, and that the concept is a convenient myth constructed to reduce responsibility, take away autonomy, and place attention on the individual rather than on social issues (Szasz, 1960; Vice, 1989). As such, the concept of mental illness might be positioned as a form of social regulation and as based on an unrealistic conception of social order (Szasz, 1960; Vice, 1989).

The culturally contextual factor of time is also implicated in understandings, experiences, and expressions of mental health and illness (Fancher, 1995). For example, the domains of psychology and psychiatry have expanded over the years, particularly within the West, from being mainly concerned with dealing with the 'severely' ill and restricted to practice within asylums, to being concerned with more common experiences of distress (Fancher, 1995). There has also been a shift in focus toward such values as autonomy, personal freedom, and individual well-being, and away from dealing mainly with those who were considered incapable of caring for themselves. According to Fancher (1995):

> The war [World War II] and its aftermath changed notions of what counted as a good life. Individualism and social mobility as social norms accelerated dramatically. Various social dynamics contributed to this, including new technology and forms of industrial production, radically expanded access to higher education, and the advance of women into the workplace. Combined with the hyperdemocratic ideology of World War II and the Cold War, these forces reshaped popular ideas of good and evil – and this changed what was considered pathological and what was considered healthy. (p. 92)

This shift in conceptions of mental health and illness has been positioned as also being influenced by a shift toward greater "individualism, Protestant meliorism [meliorism is "the belief that the world can be made better by human effort" (Meliorism, 2014)] and perfectibility and the Enlightenment ideal of normal persons as rational individuals" (Fancher, 1995, p. 55). Focus of the psy-disciplines moved toward a greater emphasis on helping individuals return to a 'normal state,' which included being "rational, free, [and a] progressive individual" (p. 55), arguably resulting in an expansion in what is considered to fall within the domain of mental health and illness (Fancher, 1995).

This shift is in line with what has been termed medicalization (Conrad, 1992, 2005). In his discussion of medicalization, Conrad (1992, 2005) positioned medicalization as the expanding of what is considered medical. This notion of medicalization lends itself to a discussion of the shifting diagnosis and definitions of mental illness. Further, medicalization has been noted as a potential form of social control – those who define normal and deviance have power (1992). This notion of social control through medicalization fits with other arguments, such as that of Szasz (1960; Vice, 1989), that position mental illness specifically as a form of social regulation that reduces individual responsibility and autonomy. Previously the main drivers of medicalization were considered physicians, as gatekeepers and experts of medicine, but Conrad (2005) has argued that, with such trends as the changing authority of physicians, there is a move towards medicalization being driven by consumerism and the economic market.

1.2 Diagnosis and Treatment of Depression

Depression is a relatively commonly diagnosed 'mental illness,' with prevalence rates between 8-12%, depending on the country in question (WHO, 2012). Depression is also "two to three times more common[ly diagnosed] in women" (WHO, 2012, p. 9). As with rates of depression, women are more than twice as likely as men to receive a prescription for an

antidepressant (Pratt et al., 2011). Currently, a biomedical conception of depression provides the dominant discourse through which depression is framed, with less focus placed on the sociocultural contexts of the experience of distress (Astbury, 2006; Lafrance, 2009; Martin, 2009; Russel, 1995). Following the dominant egocentric conception of self (Kirmayer, 2007) within Western cultural contexts, many of these explanations focus on the individual as the locus of the problem and therefore the one in need of treatment or alteration (Belle, 2003; Bullock, 2004; Ussher, 2010).

There have been various theories that postulate why women are diagnosed with and treated for depression at higher rates than men (Ussher, 2010). The biomedical model is one way in which this discrepancy is explained (Ussher, 2010). For example, it has been postulated that variations in levels of hormones and neurochemicals between men and women could explain the gender discrepancy in rates of diagnosis of depression (Ussher, 2010). Others have argued that the disproportionate rate of diagnosis of depression among women may be, at least partly, the result of living within a patriarchal society (Belle, & Doucet, 2003; Bullock, 2004; Cosgrove, & Riddle, 2004; Javed, 2004; Lafrance, 2009; Shafter, 1989; Status of Women Canada, 2013; Ussher, 1990, 2010; Varcoe, 2009). Expanding on this argument, women experience various forms of oppression, discrimination, and inequality, as well as face various unrealistic gender role expectations, such as those related to family and household responsibilities, which might account for part of the gender discrepancy in rates of diagnosis of depression (Belle, & Doucet, 2003; Bullock, 2004; Cosgrove, & Riddle, 2004; Javed, 2004; Lafrance, 2009; Shafter, 1989; Status of Women Canada, 2013; Ussher, 1990, 2010; Varcoe, 2009). Further, it is argued that a dominant biomedical conception of depression is reductionistic, oversimplistic, and ignores the complexity of women's experiences of distress (Belle, & Doucet, 2003; Bullock, 2004; Cosgrove, & Riddle, 2004; Russel, 1995; Ussher, 1990, 2010; Varcoe, 2009). Proponents of this perspective attend to the disproportionate rates of victimization women experience across the life span, such as in the form of sexual assault and spousal abuse, which is associated with poor health outcomes, particularly those related to mental health (Ali, Caplan, & Fragnant, 2010; Lafrance, 2009; Varcoe, 2009; White & Frabutt, 2006). Similarly, women, particularly single mothers, make up a large portion of those who live in poverty, and those working at low paying and part-time jobs (Belle, & Doucet, 2003; Bullock, 2004). Women also continue to experience a gendered wage gap within the workplace (OECD, 2012). Such conditions as living in poverty

have been associated with depression among women (Belle, & Doucet, 2003; Lafrance, 2009). Gender role expectations have also been argued to be associated with poor (mental) health outcomes, particularly depression (Lafrance, 2009; Lafrance & Stoppard, 2006; Ussher, 1990, 2010). For example, women face unrealistic expectations about being a 'good mother,' continue to do disproportionate amounts of housework and childcare, and are subjected to unattainable beauty ideals (Ali et al., 2010; American Psychological Association, 2010; Belle, & Doucet, 2003; Bullock, 2004; Kilbourne, 2000; Lafrance, 2009; Lafrance & Stoppard, 2006; Status of Women Canada, 2013; Ussher, 1990, 2010). These unrealistic expectations placed on women, which often reinforce gender stereotypes, have been associated with distress among women, such as that which is labeled depression (American Psychological Association, 2010; Lafrance, 2009; Ussher, 1990).

Following this line of reasoning, depression is situated as a socioculturally specific and validated idiom of distress (Nichter, 1981) through which women can express their misery and distress, and have their experiences of distress validated within the public arena (Lafrance, 2009; Lafrance & Stoppard, 2006; Martin, 2009; Ussher, 2010). Through the positioning of experiences of distress as depression, women are arguably able to have their experiences of distress validated without giving up the valued subject position of the 'good woman' (Lafrance & Stoppard, 2006; Stoppard & Gammell, 2003; Ussher, 2010). That is, they can reduce household chores, positioning the depression as the main reason for reduction in responsibilities, rather than the reduction in responsibilities or obligations being positioned as a direct and intentional rejection of their expected roles (Lafrance & Stoppard, 2006; Stoppard & Gammell, 2003; Ussher, 2010). As such, a treatment that focuses on alleviating symptoms of depression, such as through the prescription of antidepressants, which is in line with a biomedical model of depression and egocentric conception of self, allows women to cope with the distress of their everyday lives, while continuing to fulfill their expected roles (Lafrance & Stoppard, 2006; Stoppard & Gammell, 2003; Ussher, 2010). This medicalization of women's distress arguably works to make relatively invisible the various inequalities and forms of oppression women experience, and works to maintain this status quo of inequality and oppression (Belle & Doucet, 2003; Bolaria & Bolaria, 2009; Bullock, 2004; Jared, 2004; Lafrance, 2009; Ussher, 2010).

1.3 How Women Talk About Depression and Treatment

Just as it is important to explore the ways in which depression and women's experience of it have been theorized and talked about within academia, it is equally important to explore the ways in which women make sense of depression in general and their own experiences of depression specifically. Do women rely mostly on medicalized conceptions of depression? Do women talk about or implicate their sociocultural context in talking about becoming or being depressed? How do women talk about their treatment experience? Though it can be argued that the prominence of the biomedical model within such cultural media as advertising might work to frame lay understandings of depression and its treatment in biomedical terms (Gardner, 2003), this position does not take into account the agency of the individual, as well as the complexities and nuances involved in the making of meaning. For example, in her research on Alzheimer's disease, Lock (2012) showed that individuals did not supplant their understandings of the disease with biomedical and scientific ones but, instead, integrated medical models of risk with other available ways of conceptualizing. Similarly, various scholars have also demonstrated how meaning is something that is constantly in flux and being negotiated through a reflection on past experiences and future projections (Crotty, 1998; Garro & Yarris, 2009; Turner, 1989).

Researchers have begun to explore the ways in which the public in general, and women specifically, talk about depression, including exploring the ways in which their talk is impacted by the dominant biomedical discourse of Western culture. When talking about depression, many women invoke the biomedical discourse, such as in talking about a neurochemical imbalance as being a main determinant of their having become depressed, and positioning depression as primarily a medical illness necessitating medical treatment (Lafrance & Stoppard, 2006; Sigurdson & McMullen, 2013; Stoppard & Gammell, 2003). Similarly, when talking about the controversy about the over- and under-diagnosis of depression and its treatment with antidepressants, individuals often make a distinction between 'real' medical depression and normal experiences of distress, emphasising the importance of medical treatment for 'real' depression (Sigurdson & McMullen, 2013).

Though women do take up the dominant biomedical discourse surrounding depression, there is also evidence that women take on a more complex, nuanced, and varied understandings of depression (Lafrance & Stoppard, 2006; Sigurdson & McMullen, 2013; Stoppard & Gammell, 2003; McMullen, 1999, 2003; McMullen & Herman, 2009). If focus is shifted to women who have taken antidepressants but have chosen to stop taking them, many women draw on the social

factors related to their experience of depression and the fact that medication might be an ineffective solution to dealing with these social problems and 'becoming well' (McMullen & Herman, 2009). At the same time, some women talk about how the diagnosis of depression allowed them to cut back on some of their expected tasks, and take more time to relax, or more time for themselves, the diagnosis being positioned as legitimizing this reduction in their schedules (Lafrance, 2009; Lafrance & Stoppard, 2006; Stoppard & Gammell, 2003). As such, the sociocultural context in which women reside is problematized and positioned, if indirectly, as a potentially contributing factor in their becoming depressed or getting well (Lafrance, 2009; Lafrance & Stoppard, 2006; Stoppard & Gammell, 2003). Similarly, some researchers have noted that the analogy between depression and diabetes, an analogy noted as drawn upon by various groups such as pharmaceutical companies, is problematized by other populations (McMullen & Sigurdson, 2013). Arguably, this analogy works to validate depression as a medical condition and can reduce stigma associated with depression (McMullen & Sigurdson, 2013). Individuals who are long-term users of antidepressants often problematized the analogy between depression and diabetes, and antidepressants and insulin (which are used to treat depression and diabetes respectively), by bringing the distinction between body and mind to the foreground (McMullen & Sigurdson, 2013). Diabetes is situated as something more physical or biological, and depression as something more psychological (McMullen & Sigurdson, 2013). Interestingly, while the troubling of the diabetes analogy problematizes the medicalization of depression, individuals who critique the analogy between depression and diabetes (and antidepressants and insulin) can still invoke a biomedical model of depression (McMullen & Sigurdson, 2013). That said, although biomedical discourse is mobilized in public presentations of such mood disorders as depression, there are various complexities in the ways in which the public constructs depression (Lafrance, 2009; Lafrance & Stoppard, 2006; McMullen & Sigurdson, 2013; Stoppard & Gammell, 2003). This complexity is an indication that the public does not passively consume the dominant biomedical discourse but instead negotiates its integration into a complex and nuanced meaning structure of depression.

Though researchers have explored how women talk about depression, including how they take up dominant discourses (Stoppard & Gammell, 2003), few have explored how women interact directly with these discourses when presented with them through such sources as the media. The purpose of this study is to fill this gap through exploring how women interact with

the messages within antidepressant advertisements, including the messages related to conceptions of mental health and illness in general and depression specifically. This research might provide potentially useful information related to how the public engages with the messages in DTC antidepressant advertisements, including potentially bringing to attention aspects of the ads that might not have been considered in debates surrounding their impact, but that warrant further consideration. As such, this research might inform regulatory discussions surrounding these ads through providing a more nuanced perspective related to how they are engaged with by the public. Arguably, how the public engages with the messages in the ads is equally, if not more, important than considering content when discussing their impact, yet less focus has been on looking at how the public engages with these ads in an in depth way. Some questions that inform this research project include: what extent and/or how do women critically engage with, mobilize, and/or nuance the discursive construction of depression within advertisements? How is meaning about depression constructed in the face of these dominant cultural messages?

1.4 Depression in the Media: Antidepressant Advertisements

The media are a prominent means by which cultural constructions can be shaped, reflected, and reinforced (American Psychological Association, 2010; Harper & Tiggemann, 2008; Kilbourne, 2000). The messages within various media forms, including the images and language used, have the potential to impact how members of the public understand and interact with each other (American Psychological Association, 2010; Dill, Brown, & Collins, 2008; Harper & Tiggemann, 2008; Kilbourne, 2000). For example, much research has looked at gender presentations in the media and has found that exposure to sexually objectifying and stereotyped depictions of women has the potential to impact how individuals view women, how they interact with women, and how women view themselves; exposure to sexual objectification results in greater support of gender stereotypes and greater sexual objectification in real life interactions, and females who are exposed to gender stereotypes in the media are more likely to have their career aspirations be in line with gender stereotypes (American Psychological Association, 2010; Dill et al., 2008; Fox & Bailenson, 2009; Kilbourne, 2000; Yao, Mahood, & Linz, 2010). As such, the messages in the media have the potential to shape how we come to understand and make meaning of the world around us. When it comes to understandings of mental health and illness in general, and depression specifically, the media are an influential force in shaping how

the public comes to understand these concepts. Antidepressant advertisements communicate a distinct image of what it means to be depressed (Chananie, 2005; Kleinman & Cohen, 1991; Rubin, 2004; Stepnisky, 2007), and the purpose of this study is to explore the ways in which women interact with these messages.

Antidepressant advertisements construct a very distinct image of what depression entails. First, they often rely on an egocentric conception of self when communicating information related to depression and its treatment, strongly reflecting the dominant Western cultural context (Chananie, 2005; Kleinman & Cohen, 1991; Rubin, 2004; Stepnisky, 2007). Specifically, some researchers have indicated that focus is placed on the individual as the locus of the problem, and individual treatment is emphasised (Gardner, 2003; Grow, Park, & Han, 2006; Kleinman & Cohen, 1991; Stimson, 1975). Similarly, productivity, and returning to one's 'true self,' are stressed (Kleinman & Cohen, 1991; Stepnisky, 2007). Such emphases reflect and reinforce the values of a Western egocentric context in which focus is placed on the individual and self-fulfillment (Kleinman & Cohen, 1991; Stepnisky, 2007).

Research has shown that antidepressant ads also tend to present distinctly individualized and decontextualized constructions of depression, in which a biomedical model is emphasised without acknowledgement of the controversies associated with a distinctly biomedical model of depression and with antidepressants as being the ideal 'cure' (Gardner, 2003; Grow et al., 2006; Kleinman & Cohen, 1991; Lacasse, 2005). Within the scientific community, there are controversies about the effectiveness of antidepressants relative to placebo, other treatments (such as therapy), and exercise (Gardner, 2003). For example, some scholars argue that the efficiency rates of antidepressants are actually being bolstered by scientific practices, which result in studies that fail to find a significant result for antidepressant treatment being less likely to be published (Antonuccio, Danton, DeNelsky, Greenberg, & Gordon, 1999). Similarly, due to issues with double blind placebo experiments, in which researchers and participants might be able to identify whether a placebo has been implemented due to the presence or absence of side effects, success rates of antidepressants might again be falsely bolstered (Antonuccio et al., 1999). Further, it has also been argued that the chemical imbalance hypothesis of depression, which is often presented in antidepressant advertisements, is not actually supported by scientific evidence (Lacasse & Leo, 2005). These uncertainties are rarely presented in direct-to-consumer drug advertising (Gardner, 2003). Though one might argue that it is understandable that

uncertainties would not be emphasised due to ads having the purpose of selling a product, there are numerous regulations in place in various countries that indicate that prescription drug advertising should not falsely represent medication (Coney, 2002; Mintzes, 2006b; Zetterqvist & Mulinari, 2013). Arguably, not mentioning that there are other forms of treatment, or that there are uncertainties in relation to the medication's effectiveness, including relative efficacy, might be seen as falsely representing the medication. As such, it is evident that these advertisements tend to reflect and reinforce dominant Western cultural values and beliefs, including a reification of the biomedical model.

Dominant sociocultural stereotypes associated with gender are also communicated in these advertisements (Chananie, 2005; Grow et al., 2006; Johnson, 2004; Kleinman & Cohen, 1991). Specifically, it is argued by some researchers that they often reinforce the male authoritative voice through positioning males as the narrator within the advertisements (Chananie, 2005). Further, these advertisements are said to also reflect and reify gender roles by presenting the ways in which depression impacts the lives of women, including the impact it has on women's domestic duties and caregiving responsibilities (Kleinman & Cohen, 1991). Medication is presented as helping individuals get back to their 'normal' selves so they can continue their day-to-day routine and enjoy the life they live (ignoring the potential negative impact the individual's life circumstances might be having on the individual's experience of distress; Chananie, 2005; Grow et al., 2006; Kleinman & Cohen, 1991; Stepnisky, 2007). As such, women might be positioned as a target audience of these advertisements (Brownfield, Bernhardt, Phan, Williams, & Parker, 2013; Grow et al., 2006; Kleinman & Cohen, 1991). These ads do not bring to attention the potential that various social and cultural factors in women's lives might be contributing to their distress, and that these factors might be problematic and in need of change (Grow et al., 2006; Kleinman & Cohen, 1991; Rubin, 2004; Stimson, 1975). Instead, it is argued, these ads present a means through which women can learn to live with these unrealistic expectations, positioning the woman and her body as the issue, rather than unrealistic demands she might face (Chananie, 2005; Grow et al., 2006; Johnson, 2004; Kleinman & Cohen, 1991; Stimson, 1975). Some researcher state that the ads also rely on such tactics as shame and blame, presenting the messages that having depression and not being able to meet one's role expectations is shameful and the individual is to blame for not seeking treatment to fix the problem (Chananie, 2005). Further, when it comes to presentations of gender and gender

relations within these advertisements – despite the use of some feminist frameworks – some scholars argue that empowerment is usually presented as attainable through a pill and is individualized (Chananie, 2005). As such, following these arguments, the collective focus of feminism is lost, and the various inequalities and discrimination many women experience remain invisible (Chananie, 2005).

Many advertisements for drugs have also been found to present a biased perspective, despite regulations that attempt to reduce biases in presentation and increase overall balance in the presentation of medications (Avery, Eisenberg, & Simon, 2012; Coney, 2002; Gardner, 2003; Zetterqvist & Mulinari, 2013). For example, though there are regulations in place that attempt to ensure that accurate information is presented in advertisements, many of these advertisements present inflated efficiency rates that do not match the scientific evidence (Coney, 2002; Zetterqvist & Mulinari, 2013). Also, when it comes to presentation of risks and benefits of the medication, ads tend to emphasise benefits, while downplaying risks (Avery, Eisenberg, & Simon, 2012). Though some ads hint at alternative treatments, when presenting these alternatives they tend to be deemphasised and are depicted as undesirable – otherwise they are not mentioned at all despite their effectiveness for some individuals (Frosch, May, Tietbohl, & Pagán, 2011; Gardner, 2003; Lacasse, 2005). Similarly, when it comes to antidepressant advertisements, they tend to present depression as mainly biological and antidepressants as the best solution, when there is much debate related to this topic within the literature (Gardner, 2003; Lacasse, 2005). For example, there is debate about the effectiveness of antidepressants, and how and why they work for some individuals and not for others (Gardner, 2003; Lacasse, 2005). As such, the messages many of these advertisements convey is that depression is a mainly biological or genetic disorder that is best dealt with through medication, though this is not necessarily in line with current scientific evidence (Chananie, 2005; Gardner, 2003; Kleinman, & Cohen, 1991; Lacasse, 2005; Stimson, 1975). These research findings question whether these advertisements provide the consumer with enough quality and unbiased information to evaluate treatment options and the messages within the ads.

When it comes to direct-to-consumer antidepressant advertisements, there has been much debate as to whether they result in an overall societal net gain or are detrimental to the consumer, whether they should be more or less strictly regulated, and whether they should be permitted at all (An, 2008; Bell et al., 2010; Block, 2007; Coney, 2002; Gardner, 2003; Harker & Harker,

2007; Kleinman, & Cohen, 1991; Lacasse, 2005; Mackert & Love, 2011; Mintzes, 2006b; Rubin, 2004; Zetterqvist & Mulinari, 2013). One main argument in support of direct-to-consumer drug advertisements is that they work to educate the consumer (Callaghan, Laraway, Snycerski, & McGee, 2013; Harker & Harker, 2007; Mintzes, 2006b; Woloshin, Schwartz, Tremmel, & Welch, 2001). For example, these advertisements may inform the public about illnesses, including helping individuals realize that they are ill, and encouraging consultation with a doctor in order to obtain treatment (An, 2008; Block, 2007; Callaghan et al., 2013; Harker & Harker, 2007; Iizuka & Jin, 2005). This prompting of individuals to consult their physician might be particularly important for illnesses argued to be underdiagnosed and undertreated (An, 2008; Block, 2007; Callaghan et al., 2013; Harker & Harker, 2007; Iizuka & Jin, 2005). Rates of individuals continuing antidepressant treatment for six months has been found to be approximately 44% by some researchers, and, in the same study, approximately 56% of individuals "were considered compliant with treatment" (Sawada et al., 2009, p. 1). It has been argued by some researchers that direct-to-consumer drug ads might have the potential to impact compliance in a positive direction (Harker & Harker, 2007). It has also been argued that these ads might work to remind individuals to renew their prescription(s) (Mintzes, 2006b). Further, through the provision of health and treatment information, some researchers have postulated that these ads allow the consumer to participate in a more equal relationship with her or his health practitioner, providing the consumer with more autonomy and control within the health care context (Harker & Harker, 2007; Woloshin et al., 2001). Looking specifically at the financial aspects, some researchers have calculated that the cost of these advertisements is outweighed by financial gain – when looking mainly at such factors as the financial cost and/or benefit of appropriate and inappropriate treatment due to exposure to these advertisements, and of individuals being left untreated (Block, 2007). Overall, proponents cite that the net gain from direct-to-consumer drug advertisements is larger than the potential negative impact they might have (Block, 2007).

There are also those who are opposed to direct-to-consumer drug advertising. Some scholars argue that the gender stereotyped and reductionist presentations in such advertising, specifically antidepressant advertisements, might shape how individuals come to understand not only depression, but the world around them (Johnson, 2004; Kleinman & Cohen, 1991). Further, the ads are argued to work to reinforce gender stereotypes and inequalities, and leave larger

sociocultural issues relatively invisible (Johnson, 2004; Kleinman & Cohen, 1991). Opponents claim that these advertisements do not provide enough relevant information for the consumer to fully understand the messages and/or make an informed decision (Coney, 2002; Gardner, 2003; Kess, Bone, Kozup, & Ellen, 2008; Lacasse, 2005; Mackert & Lover, 2011; Singh & Smith, 2005; Woloshin et al., 2001). Many researchers who argue for the educational potential of these advertisements also mention that changes, such as improving the accessibility of information and providing enough information for the individual to make an informed choice, need to be made to these advertisements before they can achieve this potential (Martinez & Lewis, 2009; Mintzes, 2006b; Singh & Smith, 2005; Woloshin et al., 2001). It has also been argued that these advertisements work to undermine the authority of the physician, negatively impacting the patient-physician relationship (Iizuka & Jin, 2005; Kravitz et al., 2005; Rubin, 2004). For example, the physician might feel pressured to prescribe drugs that are requested by their patients based on information from advertising, or might feel resentment towards the patient for supposedly undermining his/her authority (Kravitz et al., 2005; McMullen, 2012; Morris et al., 1986). Similarly, there might be feelings of resentment on the part of the patient who has been refused a medication by her/his physician; patients might then choose to switch doctors after having been refused a requested drug (Kravitz et al., 2005; McMullen, 2012; Morris et al., 1986). There has also been research that has indicated that these ads might actually support the stigmatization of mental illness (Corrigan, Kosyluk, Fokuo, & Park, 2014). Finally, there have been various arguments that DTC drug ads disease monger (Arney, & Menjivar, 2014). Disease mongering has been defined as extending

> the boundaries of treatable illness to expand markets for new products [… and] can include turning ordinary ailments into medical problems, seeing mild symptoms as serious, treating personal problems as medical, seeing risks as diseases, and framing prevalence estimates to maximise potential markets. (Moynihan, Heath, & Henry, 2002, p. 886)

There have been mixed results when it comes to research on the impact of these advertisements on patients, physicians, and patient-physician relationships. For example, some researchers claim that direct-to-consumer drug advertising spending and/or exposure is associated with increased visits to physicians for the purpose of attaining a drug (Bell et al., 2010; Iizuka & Jin, 2005; Joseph et al., 2008). Spending and exposure has also been associated

with individuals being more likely to ask their doctor about a brand of medication (Bell et al., 2010; Iizuka & Jin, 2005; Joseph et al., 2008; Singh & Smith, 2005), to ask their doctor about a condition (Donohue & Berndt, 2004; Singh & Smith, 2005), to request a drug specifically (Joseph et al., 2008), or to seek further information (Bell et al., 2010; Harker & Harker, 2007). Similarly, research has shown that doctors are more likely to comply with a specific drug request from a patient than they are to either suggest another drug, another form of treatment, or no drug treatment to the patient (Huh & Langteau, 2007). Some researchers have indicated rates of physician compliance to drug requests as being as high as over 50% (Singh & Smith, 2005). Physicians also talk about how they feel pressured to comply with requests given that the patient is more autonomous now and if the request is not filled she or he might simply go to another doctor who will fill the request (McMullen, 2012). Individuals of lower income are more likely to admit to having consulted their doctor on the topic of an advertised drug, preferring a branded drug, and consulting their doctor on the topic of symptoms in the ads (Joseph et al., 2008). Though encouraging consumers to visit their doctors might be a positive aspect of the advertisements (Block, 2007; Harker & Harker, 2007), it might also result in unnecessary doctor visits, unnecessary costs being incurred due to these visits, and potentially in inappropriate treatment (Coney, 2002).

When it comes to how individuals understand specific illnesses, research has shown that exposure to antidepressant advertisements can impact perceptions of depression and its treatment (An, 2008; An et al., 2009), particularly with regard to perceived prevalence of depression (An, 2008); individuals who had better recall for brands of antidepressants had elevated perceptions of the rates of depression, and overestimated the actual rate of depression (An, 2008). Individuals who have higher levels of exposure to antidepressant ads tend to have more positive perspectives on using antidepressants, and position them as a primary treatment for depression, though this impact was found to be at least partly mediated by prior experience with depression (An et al., 2009). For example, "knowing someone suffering from clinical depression also significantly increased the likelihood of listing antidepressants as a treatment option [and] DTC [direct to consumer] ad exposure […] was not significant among participants who had experienced depressive symptoms" (An et al., 2009, p. 270). As such, antidepressant ad exposure was found to impact individuals who have experienced depressive symptoms less than individuals who had not had such experiences (An et al., 2009). These projects, which explore the impact of

advertisements on the public, tend not to explore impact in an in depth way – many rely on such data collection methods as survey methods, which might miss nuances in public construction of meaning in these ads. There is a need for a more in depth exploration of meaning construction related to these ads.

When it comes to consumer perspectives, consumers tend to be quite critical of these advertisements (Huh et al., 2004; Singh & Smith, 2005; Spake & Joseph, 2007), despite an overall neutral to positive judgement of these advertisements (Bell et al., 2010; Huh et al., 2004; Joseph et al., 2008; Singh & Smith, 2005; Spake & Joseph, 2007). For example, individuals are critical about the trustworthiness and credibility of direct-to-consumer drug advertisements; they are aware that these advertisements are intended to sell products, and that they might not be a credible source of information (Huh et al., 2004; Spake & Joseph, 2007). These judgements can vary depending on numerous variables related to the audience and medium of the ads (Joseph et al., 2008; Morris et al., 1986). For example, individuals who have a lower income tend to speak of being more persuaded by the ads, and of consulting their doctor based on information presented in the ads, compared to individuals with a higher income (Joseph et al., 2008). Similarly, individuals vary on the credibility and trustworthiness they attribute to direct-to-consumer drug advertisements depending on age and the medium through which the advertisement is circulated (TV, magazines, etc.; Huh et al., 2004; Morris et al., 1986). In relation to credibility of ads, "place-based leaflets/brochures were perceived the most credible and informative medium for DTC [direct-to-consumer] advertising, followed by magazine advertising," revealing a potential variation in judgements of these ads depending on the medium through which they are presented (Huh et al., 2004, p. 53). On the other hand, consumers are skeptical about the extent to which these advertisements impact themselves (Joseph et al., 2008; Spake & Joseph, 2007) and they indicate a belief that others are more impacted by the ads than they are, even though they admit to seeking further information related to a condition or drug following an advertisement (Joseph et al., 2008; Spake & Joseph, 2007; Taylor, Bell, & Kravitz, 2011).

As noted, age may be a particularly relevant variable to consider when exploring how the public interacts with DTC drug ads in general, and information related to depression and its treatment specifically. For example, some researchers have noted that "older subjects had more positive views of the drug and the ad, were more receptive to the doctor's advice and were more

concerned about disease" (Morris et al., 1986, p. 629). Further, comfort in taking antidepressants has been found to vary by age (Stoppard & Gammell, 2003), as well as perception of drug advertising (Huh et al., 2004; Morris et al., 1986). This engagement with treatment for depression is particularly significant to consider when it is taken into account that the focus of this research project is on DTC antidepressant advertisements and the related communications within them. Specifically, some qualitative researchers have noted that 'older women' (women between 47 and 66) relative to 'younger women' (between 19 and early thirties) spoke more of being comfortable with continuing antidepressant treatment and preferred not to stop treatment (Stoppard & Gammell, 2003). Younger women (between 19 and early 30s) spoke of feeling less comfortable with continuing antidepressant treatment, and spoke more of wanting to learn to cope with stressors and eventually be able to get by without medication (Stoppard & Gammell, 2003). Similarly, the rates of women using antidepressants has been found to vary by age (Pratt et al., 2011). Specifically, rates of female Americans taking antidepressants between 2005-2008 was found to be 4.6% among those 12-27, 9.2% among those 18-39, 22.8% among those 40-59, and 18.6% among those 60 years and older (Pratt et al., 2011). The differences in rates of antidepressant use between these age groups was found to be statistically significant (Pratt et al., 2011). As such, age appears to be a relevant variable to consider when discussing how women interact with DTC antidepressant TV ads specifically. As such, it can be concluded that the audience is not necessarily a passive consumer of these advertisements; rather, many factors might be implicated in how individuals interact with the messages of these advertisements and are impacted by them.

Currently, there are only two countries – the United States (US) and New Zealand - that allow direct-to-consumer advertising for prescription drugs, though other counties, such as Canada, have considered altering regulations to allow these types of ads (Gardner, 2003; Mintzes, 2006b). In Canada, there are currently regulations that restrict the type of advertisements for prescription medication; only ads that are considered reminder ads – "these ads include only the brand name and no health claims or hints about the product's use" (Mintzes, 2006b, p. 1) – and "disease-oriented or help-seeking ads" (Mintzes, 2006b, p. 1) – that encourage individuals to talk to their doctor about such things as symptoms or a condition but do not mention a specific form of treatment – are permitted (Mintzes, 2006b). Though these regulations are in place,

> currently, US advertising that is prohibited under Canada's health protection legislation is allowed to be aired on Canadian airwaves. Similarly, magazines with a North American edition (versus split-run editions) can be sold in Canada with prescription drug and tobacco ads (Mintzes, 2006b, p. 33).

This means that Canadians, despite regulatory guidelines, might still be exposed to such antidepressant advertisements as those aired in the US and New Zealand.

There have been various criticisms of the effectiveness of regulation about prescription drug advertisements (Coney, 2002; Mintzes, 2006b; Zetterqvist & Mulinari, 2013). In New Zealand, it was found that many direct-to-consumer advertisements for drugs often do not meet the guidelines set by regulations for this form of advertising (Coney, 2002). In some countries, such as Sweden and New Zealand, when an ad does not meet regulations and has to be removed, the ad has to first be identified, a complaint has to be made, the case has to be taken up within the appropriate regulatory bodies, and a warning or request for the cessation of the ad has to be issued (Coney, 2002; Zetterqvist & Mulinari, 2013). This process involves a time delay between the publication of the ad and its removal from circulation, resulting in the public being exposed to the ad for an extended period of time, in some instances that time being the intended duration or life span of the specific ad campaign (Zetterqvist & Mulinari, 2013). Offending companies are fined, though it is argued that these fines are not a significant or sufficient deterrent to printing or airing ads that do not fit guidelines, as the benefits (such as financial gains) of printing or airing these ads likely outweigh the cost of paying the fine (Zetterqvist & Mulinari, 2013). Many drug companies continue to circulate offending ads (Coney, 2002; Zetterqvist & Mulinari, 2013). Though these flaws in regulations were found in Sweden, a link was made between the largely self-regulatory systems for direct-to-consumer drug advertisements in Sweden and the regulatory system in place in Canada (Zetterqvist & Mulinari, 2013). There have been claims that there needs to be better enforcement of regulations related to direct-to-consumer drug advertisements in Canada, such as through more "active monitoring" (Mintzes, 2006b, p. 33), improving how complaints are dealt with, and implementing better deterrents for repeat offenders, all of which are arguments that are similar to those that have been made in regard to the regulatory system in Sweden (Mintzes, 2006b; Zetterqvist & Mulinari, 2013). As such, the Canadian public, though seemingly 'protected' by various regulations in place through the Health Protection Legislation,

might still be exposed to advertisements that do not follow these regulations, and instead be presented with biased health information through the media (Mintzes, 2006b).

Though researchers have hypothesised about the potential impact of these advertisements, and have attempted to quantify their impact in order to inform regulatory judgements and guidelines, few have explored how the public actually makes meaning of the messages in these advertisements or interacts with them directly. Although there is research indicating that individuals do not passively consume health messages (Huh et al., 2004; Lock, 2012; Spake & Joseph, 2007) but rather integrate them into a complex, nuanced, and flexible meaning structure (Lock, 2012), few researchers have explored the ways in which the public makes meaning of, evaluates, and interacts with the health messages in antidepressant advertisements. This research intends to fill a gap within the literature by qualitatively exploring how consumers directly engage with the construction of depression within antidepressant advertisements. More specifically, interest of this research project is in how the public interact with, negotiate, take up and/or shape discourses related to depression in interacting with DTC antidepressant advertisements. Not only will this research address a gap in current knowledge by exploring participants' understandings of the advertisements, it might also provide potentially valuable information related to the communication of health information and how individuals negotiate the meaning of mental health and treatment-related information. The results might additionally help inform public health policy in relation to antidepressant advertising through nuancing understandings of how the public interacts with and is impacted by them. Though it might be important to discuss the content of these ads when exploring their impact, how the public makes meaning of the messages and engages with them is arguably as important, if not more important, when considering their impact. Following this reasoning, the lack of research looking at how the public makes meaning of the messages in these ads in an in depth way is a significant gap in the research.

1.5 Summary

In this chapter I provided an overview of relevant literature related to the topic of how women interact with direct-to-consumer antidepressant TV advertisements. I began with a discussion of mental health and culture, followed by an exploration of conceptions of depression specifically. In addition to discussing how academia has discussed depression, it was deemed equally important to consider how the public engages with notions of depression and treatment.

As such, I presented some available research on how the public makes meaning of and talks about depression and treatment. Finally, this led me into an engagement with academic debates surrounding direct-to-consumer drug advertisements, from which emerged the purpose and question of the current research project – how do women interact with and make meaning of the messages in direct-to-consumer antidepressant TV advertisements. The open and exploratory nature of this question is based on the lack of direct research on the topic. This research has the potential to add to current debates surrounding DTC drug ads, as well as add to our understanding of how the public negotiates health messages from different sources.

CHAPTER 2
METHODOLOGY

2.1 Introduction

In this chapter I discuss the methodology used to explore how women make meaning of the messages in direct-to-consumer antidepressant TV ads. I start by presenting the overall procedures for the research project, followed by providing more information about the participants of the study. Next I look at data collection methods. Finally, there is a discussion of the analysis used, including epistemological and ontological perspectives that shape the overall analysis.

2.2 Procedures

Semi-structured focus groups, with video examples of TV antidepressant advertisement as prompts for discussion, were used to address this gap in knowledge. Focus groups have been positioned as ideal for exploring meanings of health and illness. For example, Sue Wilkinson (1998) has indicated that "focus groups offer an opportunity for researchers to observe how people interactively construct the meanings attributed to health and illness" (p. 338). Further, she has discussed how focus groups allow for in depth discussion and elaboration through participants engaging with each other (e.g. questioning, agreeing with, and disagreeing with each other, and asking for clarification; Wilkinson, 1998). This encouragement of in depth discussion is ideal for this project, as I attempt to explore in an in depth way how women engage with the messages in DTC antidepressant ads. Further, focus groups can provide less control to the researcher compared to individual interviews, which might be ideal when one is exploring participants' talk (which I do in this project through the use of discourse analysis). For example, the participants are able to direct conversation more, with less structuring of discussion by the researcher. This relinquishing of some control to the participants might also allow for areas not previously thought by researchers to be important to the research topic to be given space to be communicated.

Two to three ads, depending on time, were used with each focus group, with the ordering of the presentation of the ads having been varied. All three advertisements were viewed in all but one group, which only viewed two ads due to time constraints. The ads that were chosen for the focus groups were ads that directly specify the name of the medication in question and that indicated that the medication is a potential treatment for depression or depressive symptoms. The

specific antidepressants referenced in these ads were Cymbalta, Pristique, and Zoloft. The specific ads were identified using a general online search for DTC drug ads for antidepressants. The ads were chosen based on accessibility and taken from various online sources (e.g., YouTube). The ads were played using a computer and 24" computer screen. Before showing the ads, I let the participants know that if the advertisement was not loud enough that they could simply mention it and I would turn up the volume. Further, I made sure to ask the group if they could see the advertisement without difficulty, and noted that if they wanted me to repeat the ad at any time, to simply mention it and I would do so. Though there are regulations in Canada that restrict the airing of such advertisements, as mentioned earlier, there are various loopholes to these regulations that might result in Canadians being exposed to these ads (Mintzes, 2006b). As such, it was reasoned that exposing participants to these advertisements would not result in a higher level of risk to participants than would be expected in participants' everyday life interactions with the media. A list of the advertisements that were shown in the focus groups can be found in Appendix A.

I took on a supporting, rather than dominant, role within the focus group: I introduced the topic(s), kept the group on topic, asked questions from a question guide (see Appendix B), while trying to reduce the extent to which I limited the scope of issues that were brought to attention (Krueger & Casey, 2009; Wilkinson, 1999). As such, though I had a set of questions to encourage initial discussion, I used prompts based on participants' discussion to allow for in depth discussion. Although I intended to take a more passive role within the group, I do acknowledge that my presence and interactions with the group did influence the discussion, including what got discussed (Krueger & Casey, 2009; Wilkinson, 1999). While focus groups have been argued to allow for a more 'realistic' setting relative to such settings as interviews, I acknowledge that talk occurs within and is shaped by context (Krueger & Casey, 2009; Wilkinson, 1999). For example, although focus groups allow for interactions between various participants, rather than only the participant(s) and the researcher, they are still regulated to a varying extent by the researcher, and there are likely differences between how participants interact within focus groups in comparison to naturally occurring social interactions.

The size of the focus groups was important (Krueger & Casey, 2009). When dealing with relatively familiar and simple topics, large groups of up to 12 individuals can work to address the topic of study; as the topic or questions of the study become less familiar or the topic

requires more reflection and discussion on the part of participants, smaller groups are ideal (Krueger & Casey, 2009). For the purpose of the current study, I conducted six focus groups, each with between 4-6 individuals. More specifically, group one, two, three, and six included five participants each; there were four participants in group four, and three in group five. Because the purpose of the study was not simply to get a preliminary sense of how individuals react to antidepressant advertisements, or whether they 'correctly' understood the messages, but to explore how meaning was made in the context of these advertisements, it was important to provide the opportunity for a more nuanced and in-depth discussion to unfold (Krueger & Casey, 2009). The chosen group sizes helped achieve these goals (Krueger & Casey, 2009).

The focus groups took place in a third floor board room in the Saskatoon Community Service Village. The purpose of having this specific community-based area for the focus groups was that having the focus groups on the university campus might have been difficult and/or inconvenient for participants, particularly those who were not staff, faculty or students of the university. The specific room used was spacious, had many windows, contained several rectangular tables that were arranged into a medium sized square to accommodate the specific number of participants, and padded office chairs. Refreshments were arranged on a table at the back of the room. Though the focus groups were held on the third floor of the building, the building was very accessible, with an elevator that could be taken to get to the third floor, ramps, and double wide doorways to the room the focus group was held in. This accessibility turned out to be particularly relevant, as one of the participants did have a mobility aid device that would have made getting to the focus group otherwise difficult. The building also provided an ideal location for the focus groups, as it houses many organizations focused on women (e.g., the YWCA).

The focus groups were scheduled for 1-2 hours, though most ran closer to the 2-hour limit. This 2-hour time limit included the time for participants to settle in and completion of relevant documentation (e.g., consent forms, debriefing forms, and the distribution of monetary compensation).

Participants were recruited through the use of poster advertisements (see Appendix C), which were placed in various areas, including pharmacies, throughout the university campus, on outdoor community bulletins, and in public libraries. The advertisement was also placed on the University of Saskatchewan's PAWS site, and on the advertising site Kijiji. Participants were

given $20 compensation. Krueger and Casey (2009) have noted that "Incentives are needed because it takes effort to participate in a focus group. [For example,] the participant must promise to reserve a time on their schedule. […] Furthermore, the participant incurs financial and emotional expenses to participate" (p. 77). Compensation of $20 was determined to be an amount that would provide slight incentive to participation, without contributing undue influence for participants to participate. Though some researchers have noted that compensation of $10-20 might not be a sufficient incentive to participate, refreshments were also be provided, which some scholars have noted can be considered a form of "nonmonetary incentive" (Krueger & Casey, 2009, p. 79).

After participants had communicated interest in participating via email or phone, they were contacted and individually administered a brief demographic questionnaire (see Appendix D). This questionnaire was intended to situate participant data. The rationale for administering this brief demographic form before the focus groups took place was that the age-related information would be used to determine which set of focus groups would be offered to individual participants, which I will discuss further in the next section regarding participants. The participants who communicated interest and completed the demographic questionnaire were informed of the already set available dates (usually 2 options) for the focus groups (depending on age) on a first come first serve basis; as each group filled up, it was no longer offered to individuals who had communicated interest at a later point. I attempted to have some groups in the morning/afternoon, as well as in the evening, in order to accommodate participants' potentially varying schedules. This method of arranging group dates and times worked well due to constraints in needing to book rooms in advance, while accommodating participants' schedules. A reminder email or phone call was made/sent about a day before each focus group in order to verify attendance. If a person noted that she was no longer able to attend, I contacted other participants who communicated interest and informed them of the opening and inquired as to whether they would be interested and able to attend the newly opened space. Again, preference was given to those who had communicated interest first.

Upon arrival, participants were asked to complete consent forms, which included a reiteration that participation was voluntary and that the participants could refuse to participate at any time without any type of penalty. As the consent forms were handed out (one for their documentation and one to sign and return to me), I also gave a verbal overview of it (See

Appendix E for consent form). Within the consent form it was requested that all participants keep information communicated within the focus groups confidential, as well as that participants be respectful of each other. It should be noted that this research received ethics approval from the University of Saskatchewan research ethics board (see Appendix F for a copy of ethics approval form, and Appendix G for a copy of the ethics renewal approval form). There were a few times where participants did arrive after the focus group had started, and in these cases the participant was given the consent form and time to fill it out before the focus group continued. I also attempted to brief the participants who arrived later on the discussion of the group. Debriefing forms and monetary compensation were provided at the end of the focus group. I also requested that participants fill out a simple receipt (see Appendix H) to verify that the monetary compensation was given for funding purposes.

Participants were provided writing utensils and paper, as well as a name card. The purpose of the utensils and paper was to allow participants to take notes should they have wanted to. The purpose of the name cards was to help participants become acquainted and comfortable with each other.

Before the focus group began, and after all participants were settled, I attempted to start a very informal discussion of advertising in order to help the participants get more comfortable within the group. Specifically, I asked, in a general fashion, whether anyone had recently seen a memorable advertisement, whether it was a TV, a poster, magazine ad etc., that they could mention. If participants seemed reluctant to start this conversation, I provided the first example. This method seemed to work very well as an 'ice breaker', and frequently resulted in joking and laughing among the participants. The discussion of ads in general was used as a segue into the showing of the first antidepressant advertisement.

2.3 Participants

Women were recruited as participants in this study – any woman over the age of 18 was eligible to participate in this study. There were several reasons for choosing to focus on women as the sample for the current study. First, women are more likely to be diagnosed with depression than men (WHO, 2012); they are more likely to be prescribed an antidepressant (Pratt et al., 2011); and they are considered a target audience of direct-to-consumer drug advertisements (Brownfield et al., 2013; Kleinman & Cohen, 1991). Second, when conducting focus groups, it is ideal to have focus groups that are relatively homogenous on relevant variables to the study, as

homogeneity has been argued to facilitate discussion (Krueger & Casey, 2009). When it comes to gender within focus groups, men tend to dominate conversation, resulting in women taking a less active role within the group (Krueger & Casey, 2009). As such, it was reasoned that having only women as the participants in the focus groups might serve to facilitate discussion within the group.

Age was also considered when constructing focus groups. As noted earlier, age may be related to how the public interacts with DTC drug ads, and how they talk about antidepressant treatment (Morris et al., 1986; Stoppard & Gammell, 2003) and, as such, was considered a potentially relevant variable to consider in the current study. Specifically, I intended to offer one set of focus groups to women who were 'younger', and one set to women who were 'older'. Though other studies have explored how age relates to perceptions of drug and/or drug advertising, much of this research has been correlational (Huh et al., 2004; Morris et al., 1986), and therefore less useful in determining an appropriate age range for the current study. As such, the age 'grouping' was done in a flexible manner, and was based on the age range of participants who indicated interest in participation. The reason for this flexible determination of 'age group' was that having an inflexible distinction in age 'grouping' might have artificially separated participants. The group composition ended up as follows: group 1 (28, 35, 34, 32, 26), group 2 (26, 26, 18, 26, 29), group 3 (24, 27, 25, 24, 26), group 4 (38, 51, 37, 32), group 5 (28, 19, 23), and group 6 (35, 40, 55, 38, 41). The purpose of the separation by age was similar to that related to the gender restriction; when groups are more homogenous, discussion within the group is promoted (Krueger & Casey, 2009).

For the current project, I chose not to recruit based on, or gather information related to, experience with depression due to the potentially sensitive nature of the information. Based on communications with participants, it was informally made evident that many of the participants had close experience with depression. For example, some participants talked about having a friend with depression, a family member, an offspring, and/or a spouse who has/had depression. Some participants also spoke of having had depression and/or taking antidepressants themselves. Based on this participant information, and the evidence from the literature that experience with depression might interact with the impact of DTC antidepressant advertisements (An et al., 2009), it is possible that the focus group conversations were shaped, in part, by these experiences. For example, some research has identified that individuals who have experienced

depression are less impacted by DTC antidepressant ads, and that if individuals have had experience with people who have had depression they are more likely to position antidepressant treatment as a potential treatment (An et al., 2009). Taking into account these findings, the women might be more critical of the ads based on these experiences, or more open to antidepressant treatment. At the same time, given the high prevalence rates of depression, it might be expected that many of the participants would have had some sort of experience with depression.

The participants were also not asked about the extent of their experience with DTC drug ads in general, antidepressant advertisements specifically, or if they had seen the ads shown. Previous research has found that those who have more exposure to these types of ads view the use of antidepressants more positively and position this form of treatment as a primary treatment (An et al., 2009). As such, level of exposure to ads might be implicated in how the women in this study interact with the ads. At the same time, I reasoned that there would be variation in the level of exposure to the ads within the group, as well as self-selection based on interest in this type of advertising. Future research might benefit from inquiring about level of experience with this general type of ads, as well as the specific ads shown, in order to view whether experience with the ads relates to how participants interact with and make meaning of them.

2.4 Material: Antidepressant advertisements

In this section I provide a brief description of each of the ads shown within the focus groups. Though I do provide this description of the ads, I would strongly encourage making reference to the ads themselves (see Appendix A) rather than relying on this description alone. This description is simply meant to give a cursory sense of the ads, and therefore does not encompass all aspects of the ads. Further, I acknowledge the subjective nature of this description, and that others will view and describe these ads differently.

In total, the Cymbalta advertisement is about one minute and sixteen seconds in length, and the engagement with risks and side effects starts around 22 seconds into the advertisements and continues until just before the end of the ad. The main slogans of the advertisement focus on an emphasis that depression hurts, and that, with depression, even simple pleasures hurt. With regard to content, the ad starts by listing some symptoms of depression, including anxiety, pain, fatigue, loss of interest, sadness, and aches. Within the ad there are three main scenarios: the first scenario shows a woman getting out of bed looking a bit gloomy and disheveled; the second

scenario depicts a man at a social gathering but he is not engaging/not talking to others and he appears sad; the third scenario focuses on a woman sitting in a chair looking very upset and/or sad, and a dog comes to her with a ball and she does not engage. The screen pans to a white screen with the Cymbalta logo and then a discussion of risks and side effects begin. As the discussion of risks and side effects begins, there seems to be a transition in the experiences of the three focal characters from the different scenarios. The woman who had difficulty getting out of bed is shown out for a walk with a male, and she is smiling and talking with the male; the man at the party is shown engaging and talking with others at the party, and is shown smiling; the woman who could not engage with the dog is shown taking the dog for a walk in a park, playing ball with the dog, and meeting a male walking a dog in the park. During this transition, the narrator of the ad discusses such things as age restrictions of Cymbalta, potential drug interactions, and such risks as liver problems, yellowing eyes or skin, dizziness, and the need to be attentive to changes in mood, thoughts of suicide, and worsening depression. The ad ends with the logo and a version of the slogan related to depression hurting, Cymbalta's ability to aid, and indicating that the listener should consult her/his physician.

Like the Cymbalta advertisement, the Pristiq ad is about one minute and sixteen seconds long, with the risks and side effects starting at about 35 seconds and ending at around one minute and ten seconds. The ad centres on the metaphor of needing to wind oneself up and presents such symptoms of depression as difficulty concentrating, sadness, interest loss, and low energy. The central character is an African American woman who works in an antique shop of sorts. The ad opens with her description of her experience with depression, including the above symptoms, and how she has to wind herself frequently due to her depression. The ad uses the image of a wind up doll that has some similar traits as the main female character to reflect this needing to wind oneself up when one has depression. Depression is positioned as not only a medical condition, but a serious one. The ad emphasises the biological nature of depression and the medication by talking about how the medication works on levels of norepinephrine and serotonin. The ad demonstrates this impact on neurochemicals in the brain by showing an image of what might be assumed to be two neurons facing each other exchanging neurochemicals (small balls being transferred from one neuron to the other). There is next a shift to discussing risks and side effects, which include acknowledging age restrictions, drug interactions, and such side effects as dizziness, nausea, and sweating, and risks of suicide, worsening depression, and

changes in mood. During the discussion of risks and side effects, the main character is shown as working in a shop and smiling, and she helps customers when they enter (implied as experiencing treatment and therefore improvement of depression symptoms due to treatment). The screen switches to the main character's face, and the audio switches from the narrator to the main character speaking. She specifically positions Pristiq as the key in her experience of treatment of depression and encourages the listener to consult his/her physician.

The Zoloft advertisement is the shortest ad at one minute in length, and with the discussion of risks and side effects starting at about 36 seconds into the ad and continuing until just before the end of the ad. Some symptoms of depression that the advertisement mentions include hopelessness, anxiety, exhaustion, sadness, lack of enjoyment of previously enjoyed things, and loneliness. The main character is an oval shaped white cartoon character that looks glum and is followed by a gray cloud raining on the cartoon character. A blue bird flies around the character chirping but the character does not interact and slowly continues moving forward with the cloud following it. Depression is positioned as potentially related to levels of neurochemicals, though the narrator does say that the specific cause of depression is unknown. The screen pans to two neurons facing each other with small circular items passing between them, with the narrator indicating that Zoloft helps to correct the indicated imbalance in neurochemicals. The screen pans back to the cartoon character, the cloud starts to dissipate, the cartoon character begins jumping forward instead of dragging forward, and the character is smiling and acknowledging the blue bird. At this time the narrator starts to discuss side effects and risks of Zoloft, including potential medication interactions, as well as such side effects as sexual problems, dry mouth, diarrhea, tiredness, insomnia, and nausea. The ad ends with an indication that the listener should consult her/his physician about Zoloft, emphasising that more knowledge about what is wrong can aid in correcting the issue (depression).

2.5 Data collection

Focus groups were recorded using two audio recording devices, with the permission of participants. A male note-taker sat in on most of the focus groups in order to help with the subsequent transcription process. He sat at a table off to the side of the group in order to reduce potential distraction. My own note taking was kept to a minimum, so as not to distract participants or result in my being disengaged from the group. These forms of data collection were used to facilitate transcription of group discussion, which aided analysis.

Transcription was done using a word processing program, and transcript notation was used to support and facilitate working with and analysis of the transcripts. The particular transcript notation that was used was an adapted version of that presented by Lafrance (2009, p. 206-207), which is "a modified version of the transcript notations presented in Potter and Wetherell (1987) and Wood and Kroger (2000) and previously developed by Gail Jefferson" (p. 206). The specific adapted notation can be found in Appendix I. All identifying information was removed from transcripts (such as names, and locations), and transcripts were saved on a password protected computer. Consent forms were stored securely and separately from data collected, so as to maintain participant confidentiality. Further, in the transcription, participant numbers were used to refer to participants in the data for purposes of confidentiality.

2.6 Analysis

Discourse analysis was used to identify how participants talked about the ways in which depression was presented in the antidepressant advertisements. In particular, I focused on how patterns of language used "together produce […] particular version[s] of events" (Burr, 1995, p. 48). As such, the questions of "how […] discourse is put together, and what is gained by this construction" (Potter & Wetherell, 1987, p. 160) guided the current research project and the analysis of the focus group transcripts. The approach to discourse analysis presented by Potter and Wetherell (1987), Potter (1996), and Wood and Kroger (2000) in which the performative and constructive nature of talk is emphasised, was used. As such, the following assumptions were made:

1. Language is used for a variety of functions and its use has a variety of consequences;
2. Language is both constructed and constructive;
3. The same phenomenon can be described in a number of different ways;
4. There will, therefore, be considerable variation in accounts;
5. There is, as yet, no foolproof way to deal with this variation and to sift accounts which are 'literal' or 'accurate' from those which are rhetorical or merely misguided thereby escaping the problems variation raises for researchers with a 'realistic' model of language;
6. The constructive and flexible ways in which language is used should themselves become a central topic of study. (Potter and Wetherell, 1987, p. 35)

It was evident that a 'realist' perspective was not in line with this approach to discourse analysis (Potter and Wetherell, 1987) and therefore a critical realist ontology and social constructionist epistemology were adopted (Crotty, 1998; Lafrance, 2009; Ussher, 2010). This perspective, like Crotty's (1998) social constructionist perspective, acknowledges the existence of an objective reality, but questions our ability to objectively represent that reality (Lafrance, 2009; Ussher, 2010). Meaning is positioned as constructed through interactions with the objective world (Crotty, 1998; Lafrance, 2009; Ussher, 2010). As such, this perspective emphasizes the flexibility of meaning and the interconnection between the objective and the subjective (Crotty, 1998; Lafrance, 2009; Ussher, 2010). This ontological and epistemological framework was also in line with the goal of the current study, which was to explore the construction of meaning, rather than to assess the objective 'truthfulness' in participants' talk. This framework has also been positioned as an ideal perspective through which to explore the topic area of depression, as it acknowledges the reality of the experienced distress of depression, but also acknowledges that that experience is inevitably mediated by the subjectivity of meaning and by the sociocultural contexts in which meaning making occurs (Lafrance, 2009; Ussher, 2010).

2.7 Summary

In this chapter on methodology, I covered the various aspects of how the research project was conceptualized and took place. I began with a detailing of the procedures of the research project, including such particulars as where the project took place, and how the focus groups proceeded. This was followed by a detailing of who participated in the study, including the composition of the focus groups. A discussion of data collection methods proceeded. Finally, I ended with a discussion of the analysis used, including the perspectives that informed the analysis. Through the use of the presented methodology, I will explore how women interact with and make meaning of direct-to-consumer antidepressant TV ads.

CHAPTER 3

RESULTS

3.1 Introduction

In this chapter I present the results of the study. I start with a brief introduction to some orienting concepts that were helpful in making meaning of the women's talk. These orienting concepts include exploring the notion of rhetoric, with a particular focus on Potter's (1996) engagement with the topic. Finally, I move into a discussion of specific analytic findings. More precisely, I engage with the three analytic categories identified using discourse analysis and the orienting concepts. These categories include *Reclaiming normal*, *Reclaiming depression*, and *Caution in and defence of claims*. Each of these categories are discussed in turn, beginning with a brief orienting introduction to each category, followed by the presentation of excerpt from the dataset to exemplify each category of analysis.

Across the focus groups, the women used language in multiple ways, which worked to allow them to reclaim depression from normalization and normal from pathologization, as well as to defend their claims and introduce risk in engaging with the categories. Of particular relevance to these findings is the study of rhetoric. Many scholars credit Aristotle as the founder of the study of rhetoric, with his work influencing the modern study of the topic (Kennedy, 1991). Though some theories of rhetoric may be a reaction against some of Aristotle's discussion of the art of persuasion, or not be in agreement with some of his founding ideas, there is an acknowledgement that his work at least still has reactionary influence on such work (Kennedy, 1991).

Potter's (1996) use of rhetoric in the context of fact and category construction provides a useful way of approaching the current dataset. Potter (1996) defined rhetoric as "the antagonistic relationship between versions: how a description counters an alternative description, and how it is organized in turn, to resist being countered" (p. 108). From this definition emerged two overarching categories of rhetoric – *offensive* and *defensive*. Offensive rhetoric was conceptualized as the use of rhetorical and discursive devices to undermine a description, whereas defensive rhetoric was positioned as the use of various linguistic mechanisms or resources to avoid one's own claim(s) being undermined (Potter, 1996). The participants in the current research project employ both of these rhetorical forms in various ways.

More specifically, throughout each of the first two categories of analysis – reclaiming depression and reclaiming normal – the participants engaged with the claims to depression and normal made within the advertisements. Often the presentations in the ads are undermined by the participants through the employment of offensive rhetoric. In the context of undermining the presentation of depression and normal, participants also make their own claim(s) to factuality, particularly in regard to what constitutes depression and normal. Looking at the third category of analysis – caution in and defence of claims – the use of linguistic structuring to introduce ambiguity or vagueness can be defensive rhetoric – protecting the participants' claims to reality from being undermined. This use of ambiguity or vagueness also introduces the notion of risk in the context of claims regarding normal and depression.

There are various rhetorical devices used to reclaim normal and depression, as well as introduce caution in and defence of claims. With reference to Potter's (1996) work, the participants frequently use extrematization, minimization, normalization, abnormalization, notions of stake, systematic vagueness, as well as category entitlement to reclaim depression and normal. Extrematization has been referred to as "using the extreme points on relevant descriptive dimensions" (Potter, 1996, p. 187). Minimization has been positioned as downplaying or trivialization of what is being described (Potter, 1996). Normalization has been defined as the positioning of the 'category' under description as general, mundane, or regular (Potter, 1996). Here, it is important to note that the notion of normal that Potter (1996) has noted as making up 'normalization' refers not to an overarching or superimposed theory of normal, but rather to the action of situating the 'category' under description as, for example, commonplace. In contrast, abnormalization was described as the use of description to emphasise that that which is being described is not common, or is bizarre or out of the ordinary (Potter, 1996). The notion of stake has been referred to as vested interest implicit or explicit in a description (Potter, 1996). Category entitlement has been described as the way in which "certain categories of actors are treated as entitled to know particular sorts of things, and their reports and descriptions may thus be given special credence" (Potter, 1996, p. 114). Systematic vagueness was defined as the use of linguistic resources to introduce ambiguity, such as the use of less detailed description (Potter, 1996). Systematic vagueness has typically been associated with defensive rhetoric due to its potential to protect a description from being undermined (Potter, 1996). For example, if a vague claim to reality was made, this claim can often be much more difficult to undermine than one

with more detail or that was more specific (Potter, 1996). The analysis will show how these various linguistic resources are used to reclaim depression and normal as specific and separate experiences in the context of interacting with the DTC antidepressant TV ads.

Each analytic category is described in more detail in the respective sections – reclaiming depression, followed by reclaiming normal, and caution in and defence of claims. This elaboration is followed by detailed analyses of how specific discursive resources (e.g., word choice, grammar, sentence structure, etc.,; Potter, 1996) are used to accomplish these rhetorical moves. Within the selected excerpts, the first number is used to differentiate participants within each respective group and the second number refers to the age of that participant. The number in square brackets at the end of each excerpt indicates which focus group the excerpt is taken from, and is followed by the name of the advertisement last shown. Though I provide information as to the advertisement that was viewed prior to the participants' discussion, I would caution against it being assumed that because an advertisement was the one shown before the specific excerpt that the participants are interacting with only that advertisement in the excerpt. More specifically, participants' interactions with one advertisement might be influenced by their engagement with a previously shown (or lack thereof) advertisement. The name of the advertisements last viewed before specific discussions is simply provided to give additional information about the context of the discussion.

Though the reclaiming of normal could be argued to overlap with the reclaiming of depression, such as through it being implicit in the latter, these categories warrant separate consideration for two reasons. One, though it might be consider the former is implied by the latter, the opposite is not necessarily true - reclaiming and defending normal does not necessarily imply the reclaiming and defence of depression as a separate category of experience. Two, without considering these categories separately, the nuances in what the women accomplish through their use of language are missed. As such, teasing the distinctions apart remains important.

3.2 Reclaiming Depression

Within the context of interacting with the advertisements, the participants reclaim and reify depression as a specific category of experience(s). Through the use of offensive rhetoric the advertisements are frequently positioned as insufficiently differentiating depression from alternative experiences; the implied claims about depression in the advertisement are thereby

problematized and undermined. Further, the women often position the advertisements as downplaying, oversimplifying, confusing, and/or trivializing depression. In the face of such presentations of depression and its treatment, the women position depression in such a way as to differentiate it from these alternative experiences and 'protect' it from being confused or trivialized. Their counterclaims work to reify depression as a specific, severe, serious, and uncommon experience, thereby reclaiming the category.

The presentations in the ads are frequently trivialized or downplayed (minimization), as well as associated with general or universalized experiences (a combination of minimization and normalization) by the women. Further, the participants frequently indicate that the advertisements might reflect something like the flu or cold, sadness, a lack of energy, a lack of productivity, anxiety, or simply not indicate a long enough elapse of time to designate depression (combination of minimization and normalization). Using extrematization, the participants often reference the presentations as *nothing like* depression, or at least falling short in reflecting the experience. What's more, some women bring to attention the potential stakes behind the presentation in the advertisements by highlighting the intent to sell a product. Bringing to attention stakes invested in a description or claim has been noted as able to support undermining this description (Potter, 1996).

In contrast to the presentation in the advertisements, the women present their own claims as to depression and, in doing so, attempt to reclaim it. These claims position depression as severe, uncommon, and serious. Aside from a general indication of severity, an association with medicine is often used to emphasise that depression is not these normalized experiences presented in the ads, but something serious. There is also emphasis on notions of control and agency. These linguistic resources are used in reclaiming depression from being associated with/positioned as something trivial or low grade.

What follows are examples of the various resources that are used by the participants to undermine the presentation in the ads and stake their own claims to the category. Example excerpts are provided, followed by a detailed analysis of each excerpt, with a focus on the above mentioned patterns of talk. As the women focus not only on depression itself, but also treatment, the excerpts are organized to explore how the linguistic resources are used in the context of discussing depression, followed by in the context of discussing treatment.

3.2.1 Depression

Some participants engage directly with the presentation of depression within the advertisement in the context of reclaiming depression. In this first excerpt the participants demonstrate the importance of distinguishing depression from sadness, as well as the potential detrimental outcomes of this distinction not being clear.

3(25): Ya, I agree. I feel like that's the edu**cation** [1(24): mhm], is realizing that depression and **sadness** that we all feel, that **everyone** knows what it's like to feel? They're **different**, they are very **different things**? [C: mmm] … Just trying to get that **awareness** out? That… [C: mmm] I don't know, that it's **complicated** (small laugh)[a few small laughs], I guess.

C: um… to what extent do you think the ad… **differentiates**, 'cause you said kind of there is a difference between **sadness** and **depression** kind of thing?

3(25): I don't feel like it addresses that at all [C: mm]… I feel like that's what's **missing**? is that education piece, is helping people under**staand** that there's a difference, and because I th- I… I don't know, again, I am kind of being opinionated [general laugh] sorry, but, I feel like people will **rationalize** to themselves? that this is just **sadness**, and I should just be able to get over this, and then, when the day that they **can't** get out of **bed** because it's de**bilitating**, that's when all of a sudden, you know, oh my god, I can't get out of **bed**, I'm stuck, or someone **finds** them at home and they haven't been out of bed for two **weeks**, you know, like, and I feel like some of that's **harmful**? Some of the **mind** sets that are **perpetuated** by something like this? For one thing that it's curable by a **pill**, and for another that it's something we all go through, so just… you know, I don't know… find your way **through** it, or, I don't know… I don't know if I am making sense, or just=

1(24): =Ya, cause they don't really explain, like, they are like, depression **hurts**, but they don't really explain like what depression would **be** [3(25): right], like, I almost want to say clinical **definition**, or like [3(25): that might help (laughs)], ya, like this is kind of **normal**, this **isn't** [3(25): mhm]. Like, if you feel saaad, every **day**, you know, and you

don't know **why**, that would be more in line with depression than jusst run of the mill **sadness**. Usually because with **sadness** you have **reason**, where **depression** can be just… just because=

3(25): =arbitrary

1(24): ya …
[3 Cymbalta]

The descriptive claim to depression of the ad is undermined in various ways within this excerpt. For example, the claim is undermined in the way it is indicated as falling short; 1(24) specifies a need to distinguish between what is "normal [and what] […] **isn't** […] like, if you feel sad, every day, […] and you don't know why, that would be in line with depression than just run of the mill **sadness**." The participants also state that the ad(s) "don't really explain […] like what depression would be […] like this is kind of normal and this isn't." Further, it is argued that the ad did not "at all" sufficiently make the distinctions between depression and sadness. In addition to direct references to the ad falling short, this use of 'at all' (extrematization) doubly emphasises the insufficient nature of the differentiation within the ad(s).

In addition, through normalization and minimization, sadness is positioned as normal, and, in contrast, depression as not normal. For example, sadness, beyond being a normalized experience itself, is referred to as 'just run of the mill'. 'Just' works to downplay or minimize sadness relative to depression, as well as to abnormalizes depression through contrast. 'Run of the mill' works to further normalize and minimize sadness, relative to depression, through association with common experience.

Further, 3(25) continually makes reference to there being an apparently 'clear' difference between depression and sadness. This differentiation is exemplified in the following quote, "the edu**cation** [1(24): mhm], is realizing that depression and **sadness** that we all feel, that **everyone** knows what it's like to feel? They're **different**, they are very **different things**." The difference here is emphasised through the intonation on the use of 'different,' as well as through the direct noting of a difference. Further, the participant does not only make claim to a difference, but also emphasizes that the subjects are "*very* different." Such extrematization works to construct the

distinction between depression and sadness as clear, and to undermine the presentation of depression in the ad.

The undermining of the claim to depression in the ad is further reiterated through emphasising that those who do not realize that this real difference exists lack education on the topic. Through claiming that the ad did not make this distinction and constructing those who do not acknowledge the distinction as lacking education, the credibility of the advertisement is brought into question.

We can also see here that in its positioning as uncommon, depression is similarly positioned as severe. This severity is brought to attention through contrasting the ad's presentation of depression with the participants' claims. Through juxtaposing depression with sadness that we all feel, it can be assumed that depression is being positioned as *not* something that we all feel. Emphasising that depression is not universally or commonly experienced draws attention to the severity (through rarity) of depression. Further, through attempting to articulate the difference between sadness and depression, 1(24) cautiously relies on a medical association, which works to emphasise severity and abnormality, as well as support her claim. For example, through referencing 'clinical' in the quote "I almost want to say clinical **definition**," there is an association with medical terminology. Through invoking terminology with a medical association there is a reiteration of depression as real (it has a medical definition), severe, and abnormal (a medical issue).

The participants also make reference to temporality in their reclaiming of depression. For example, they reference not being able to get out of bed for "two **weeks**." This specific reference to 'time' works to emphasise the severity of depression in several ways. One, it emphasises that depression is not experienced for '*just* one day' but rather for an extended period of time. Also note the emphasis placed on weeks, which highlights the elapse of time. Two, this reference to 'two weeks' relies on psychiatric discourse related to diagnosis, which employs a two-week criterion for a diagnosis of depression. As such, through association with dominant psychiatric diagnostic criteria, this reference solidifies and supports depression as a distinct category of experience. More subtly, this association with dominant psychiatric diagnosis imparts a connotation of seriousness and severity.

Another way in which the participants emphasise the severity of depression relative to "just sadness" is through calling on notions of personal agency and productivity. Relying on

these notions, which are highly valued within Western cultural contexts, emphasises the severity of depression in the face of its potential confusion with 'just sadness'. For example, in noting that someone might think "this is just sadness, and I should just be able to get over this," there is the implication that in experiences of depression one does not have this agency. Again referencing the lack of agency, 3(25) argues that the ad perpetuated the idea that depression is something we all go through, "so just […] find your way **through** it." In contrast, depression is positioned as *not* something we all go through. A lack of productivity (e.g., not being able to get out of bed) is further reiterated as an issue through the emphasis that is placed on the use of 'debilitating'. There is also reference here to a lack of independence and control in referencing not being *able* to get out of bed. As such, depression is positioned as severe and uncommon through contrasting it with the notion that individuals have agency.

In this next excerpt, the participants very explicitly position the advertisement as oversimplifying depression. What's more, they use notions of symptoms and physicality in their reclaiming of depression as a severe experience.

> 1(28): [inhale] well [exhale] I don't know, again it goes back to those **things**, like some of the things that they **sa:y:**.. k- it can be a **myriad** of things, like they- they're **no:t** just depressive **symptoms**, and it's just… like I think depression is so much more **multifaceted** than tha::t, a:nd it just sort of **oversimp- oversimplifiieed** how::: **depressing** (small laugh) depression **is**, I think, if that makes **senses** [C: mm]-
>
> 3(23): how depressed people **look**, like. Cause there is only like **one symptoms** that, like, ok, **two** symptoms, that depression is- looks **saad**, and it **hurts** [1(28): ya], and, that's basically **it,** [1(28): ya] that's like **two symptoms** [1(28): mhm] they don't **list** them? or anything?
>
> 3(23): mmm… like, you already **mentioned,** it's **oversimplifi::ed**, depression is mor:e… ummm… like there are **more symptoms** for **depression**, [C: mm] it's not only **mental**, it's also like fi- i- i- it-… it **transfers** to your **physical health** somehow? [C: mmm].. that's- it's not only.. the **symptoms** that they **showed.**
> [5 Cymbalta]

1(28) argues that "it [the presentation of depression within the advertisement] could be a myriad of things […] they're not just depressive symptoms." In this quote, the participant accomplishes several things. Through referencing the presentations in the ad as "things" (which is a general term) rather than "symptoms," (use of medical terminology), the participant minimizes and normalizes the presentation in the ad. Further, later reference to the advertisement as having "oversimplified how depressing depression is" indicates that these *things*, as differentiated from depressive *symptoms*, are less 'severe' than an experience of depression. As such, there is both minimization and normalization in use here to undermine the presentation of depression.

Contrarily, on several occasions, in the context of speaking about the experience of depression, the term 'symptoms' is used and even emphasised (e.g. "they're **no:t** just depressive **symptoms**"). This specific use of *symptoms* implies an association between depression and medicine, and abnormalizes the experience. As such, through positioning the presentation within the advertisement as undifferentiated "things," which is contrasted with "depressing" "depressive *symptoms*," the participants reify depression as a real and severe category of experience.

On the other hand, 3(23) does use the term 'symptoms' on several occasions to discuss the presentation of depression within the advertisement, acknowledging it as potentially presenting an experience associated with medical expertise (a medical aberration). For example, she states that "there *are* only two symptoms in the advertisement" - by implication the presentations in the advertisement *are* symptoms, despite not being exhaustive in terms of depression. As such, though more subtly here, this use of symptoms also allows for a positioning of depression as serious, while partly undermining the ad's claim to depression – the ad does not provide an exhaustive listing of symptoms (e.g. the ad presents "*only* two symptoms") and is therefore positioned as falling short in presenting depression.

Through emphasising what is 'missing' within the advertisement, the participants further position depression as within the domain of the medical, and therefore as serious and an aberration. For example, beyond referencing 'symptoms,' the participants also state that depression is "not only mental" but also "transfers to your physical health." The specification of "*health*" again positions depression within the domain of the medical. Interestingly, 3(23) specifies 'physical *health*,' but in reference to the *'mental'* aspect of depression does not directly

reference *health*. Further, through noting that depression is "not only **mental**, it's also like fi- i- i- it-… it **transfers** to your **physical health** somehow," there is an indication that depression might start as mental, and then gain a stronger association with the medical through transferring to the physical body's *health*. The mental aspect of depression is positioned as insufficient to differentiate or define depression relative to alternative experiences. Further, the physical aspect of depression appears to be key here in indicating depression as severe – it has a more secure tie to medicine, which connotes seriousness, and severity. The significance of the physical aspect of depression for emphasising the seriousness of depression is particularly relevant when considering that the participants state that the physicality is absent in the ads.

In contrast to many of the previous excerpts, in the next excerpt the participant does not directly say that the advertisement(s) fall short in making this distinction, though she does so indirectly.

> 3(55): I thought the cloud was an ok picture, I didn't mind it. Ya, I have seen a lot of the **black dog** [C: mm] um… I don't know what you **call** them, I don't like- I don't know an ad or whatever it is, but… it is sort of the idea that depression is something… like **you** said, that, I think it does give the impression that it is not something that you necessarily **caused**, or that you are responsible, [C: mm] or **whatever**, but, and it does give some parameters for what is considered **not normal**, cause everybody feels **sa:d** and has everyone **down** days… if you can't get rid of your black cloud, I guess that sort of.. the message.
> [6 Zoloft]

Here the participant references a different ad campaign, "the **black dog**," than the ad(s) shown. This alternative reference aids in the differentiation of 'normal' from depression. Reference to "the **black dog**" is a reference to resources, including informational videos, related to mood disorders provided by the Black Dog organization/institution (Black Dog Institute, 2014). This use of an alternative presentation of depression than that in the ad is an indication that the ad falls short in its presentation. Further, in saying that the ad was an "ok picture," rather than using stronger language, the value of the presentation in the ad is undermined. At the end of the excerpt, the participant states "I guess that sort of.. the message," after specifying a

difference between depression and 'normal' experiences. Through specifically using 'sort of' the participant indicates that the ad does not really encompass the distinction that she mentions as important. Further, in specifying that the ad gives 'some' parameters, there is a subtle undertone that the ad does not give *all* the parameters. As such, the participant constructs the advertisement as falling short in terms of presenting depression, particularly in the context of differentiating it from normal experiences.

At the same time, there is a contrast drawn between depression and sadness. Sadness is normalized and minimized, while depression is abnormalized and positioned as severe and serious. For example, one participant states that "it does give some parameters for what is considered **not normal**, cause everybody feels **sad** and everyone has **down** days." Here is reference to lay terminology for universalized experiences – being down or sad (with emphasis on these terms), and the use of the universalized 'we' (e.g., 'everyone' and 'everybody' – extrematization). Also, note that she does not say 'can feel' or 'can have'; she specifically says that everyone '*does'* experience these referenced things. As such, she solidifies the referenced experience as in the domain of normal and, through association, as less severe and serious experiences. Through contrast, and abnormalization, depression is differentiated from these mentioned normal experiences and is positioned as something that not *everyone* experiences. Further, the specific use of 'days' in positioning being 'down' as normal is also significant. With the specification of 'days' (rather than a longer or indeterminate amount of time), there is an indication where being down or sad might extend beyond the normal sphere. In contrast to these down *days,* depression is positioned as something more chronic or long term, which further connotes a sense of seriousness and/or severity.

As with the previous excerpts, there is a potential reference to the notion of agency as a means of reifying depression as something severe and serious. For example, through noting that depression is "if you can't get rid of your black cloud," it can assume that, in contrast, 'normal' is when you *can* get rid of the sadness and the black cloud. 'Normal,' which is associated with agency and control here, is contrasted with depression, which therefore is associated with a lack of agency and control.

3.2.2 Treatment

As mentioned, in some instances the women interact more directly with the notion of treatment in their reclaiming of depression, as in this first excerpt.

4(32): I see it as representing a lack of energy, just needing- cause that's one thing I **really** noticed, is just **no** energy [C: mhm, yeah] for anything. …

2(35): yeah, I don't know, I- I think the **clo::ud** is a **better**, like the **ho::le**, the black **hole,** or the **clo:ud**, I think the winding up, I mean that could be a **slew** of different… **ailments**, you know? Just needing kind of like an **energy**, I don't know, like? I don't know (audible exhale), I don't think the wind- I think the winding up is **ok**, it's not… **ho::r:ible**, but I don't think it's umm … as… I don't know what word I am looking for, like uh… I don't think, I don't know if I'd **look** at that, and if I was in a dis:perat- depressed… **spot?** I'd say that's, 'I need to wound up,' I don't think I'd say that, I would say 'I need to come out of this **funk**,**'** or 'I need to get out of this **ho::le**,**'** or, you know, get up out from under this **clo:ud**, that's a visual that I se- I under**sta:nd**. The winding up is like, well maybe I could take a **vitamin,** and maybe I could, you know [5(26): yeah] get a, get a **B12 shot,** or something, that might… **perk** me up

[…]

5(26): cause it's like not like it's going to **gi:ve** you **energy** right, [mhm] you're not going to be like, (sounding enthusiastic) 'yea::h!' [general laugh] It's like… Yeah, I would agree.
[1 Pristiq]

First, there is normalization and minimization of the presentation in the ad by the participants. This positioning as a normalized experience can be seen through the reference to a lack of energy – lacking energy is not necessarily pathological, but is a common experience. This use of normalization can also work as minimization in the context of discussion of depression. Not only is the presentation of a normalized experience, but it is also further minimized through the use of 'just'. For example, the presentation in the ad is of an experience that 'just' or 'only' needs the treatment that is referenced by the participant. At the same time, the reference to "not having energy for "anything" is an example of extrematization, and an acknowledgement that the

presentation in the advertisement might be of something relatively severe, despite being normalized. Further, 2(35) uses the term 'ailments' rather than something like 'illnesses'. Ailments is defined as "a physical disorder or illness, especially of a minor or chronic nature," and "a slight but often persistent illness" (Ailment, n.d). There is an acknowledgement that the presentation is chronic but not severe and, as such, this use of language by 2(35) works as a form of minimization.

2(35) struggles in various ways with differentiating the presentation within the advertisement from how she positions depression. First, there is a differentiation of depression from the presentation in the ad; the presentation is "ok" but not 'ideal'. Through making reference to the ad as presenting potentially 'a **slew** of different **ailments**,' several things can be seen. The reference and emphasis placed on '**slew**' is a use of extrematization, which brings to attention that the presentation in the advertisement is potentially a multiplicity of things and therefore not specific to depression. Further, the reference to and emphasis on 'ailments,' taken with the later reference to potentially relatively minor or common issues that can be easily treated (vitamin deficiencies), works to downplay the presentation of depression within the advertisement, while emphasising that depression is something that is not so simply or easily treated.

There is also an interesting dynamic here in which depression is reiterated as something specific and different from other ailments through contrasting it with that which might be treated with normalized treatment. For example, the participants make reference to the ad's presentation of depression as needing to 'wind yourself up,' and state that this might be treated with a vitamin or a B12 shot. The referenced treatments are positioned as something that would "**perk** me up," which also normalizes and minimizes the presentation in the advertisement. Further, 5(26) brings to attention that the medication would not 'give you energy'. The claim of a 'quick fix' for depression is situated as absurd through the emphatic use of 'yeah' and the general laughter that ensues. As such, the presentation of depression, through association with the normalized treatment, is also further minimized. In contrast, treatment for depression is positioned as helping individuals 'get out of a funk'. Depression is reclaimed as something beyond the trivialized presentation in the advertisement through engaging and contrasting with the implied treatment in the ad.

In this next excerpt, there is an interesting engagement with the notion of stake.

1(38): ya, I thi- it is certainly advertising it like a flu:, but like it- if you have a co:l:d, you know, it is like you take these tablets and you will be better in five da:y:s:, you know, it- they are advertising it like that, but for me depression is nothing like that, it- it is much more longer ter::m
[4 Zoloft]

First, the participant makes a comparison between the presentation of depression in the advertisement and the 'flu' or a 'cold'. The cold and flu are often considered medical aberrations from the 'healthy body'. At the same time, they are relatively common experiences. The cold and flu also tend to be, in general, fairly banal and easily treated. This ease of treatment is also referenced in the participant's statement "like you take these tablets and you will be better in five days" – a relatively quick 'healing' time. As such, this reference to the cold and flu is an indication that the presentation within the advertisement is positioned as a common experience, which, though an aberration from the 'healthy body,' is something easily dealt with – normalization and minimization.

This reference to the cold and flu becomes particularly relevant when considering that the participant states that "depression is nothing like that […] it is much more longer ter:m." Here, the participant uses extrematization to undermine the ad's presentation and support a counter-claim – it "is *nothing* like that." As such, in contrasting depression and the presentation in the ad, there is a reification of depression as something beyond the cold and flu, something more serious or severe. Also note the use of extrematization in the participant saying "much more" in reference to "longer term"; depression is not only slightly longer term, but *much* longer term. This reference to quantity in the context of temporality emphasises the difference in severity between depression and the alternative experiences presented within the advertisement. Through referencing how the experience in the advertisement might be treated, as well as temporality, the participant emphasises that the presentation in the ad trivializes depression.

Taking into account notions of stake, the participant's critical engagement with the advertisement, and undermining of its claims, is further supported by her use of the word 'advertising'. For example, she argues "it is certainly advertising it like the flu," and "they are advertising it like that." This use of words brings to the forefront the stakes in the presentation of

depression and treatment in the ad – to sell a product. Citing the potential intentionality in the presentation of depression raises the possibility that the ad is not necessarily 'truthful' or 'unbiased'. Additionally, this rhetorical move highlights the depiction of depression as a rendition. This positioning allows an opening of space for different or alternative renditions to be considered.

In this final excerpt related to treatment, the participants provide a particularly interesting engagement with the notion of depression as a medical illness warranting medical treatment. The engagement with the ad is less direct in this excerpt, but the ad provides the context for this discussion.

> 4(32): - I think there's a difference between **situational** depression and like **clinical** depression [5(26): ya], and that's where the **chemical** part came in [5(26): ya] cause I think there's definitely a distinction there, and your doctor can help you determine that.
>
> C: I wonder if maybe you could- or, if we together could elaborate on that distinction as well … …
>
> 4(32): um, well I guess cause it's not like the doctor can draw blood and say 'well you're depressed'. It is still based on … what you are saying your symptoms are. But I know, with my doctor it was kind of like, 'well have you had any recent life events that could be contributing to this' and kind of **probing** a little bit more? So I don't know …. I don't know, I don't know how you would actually make that distinction in words. I know that, I think sometimes you can make those changes, but sometimes that's not enough, so you have to have the added thing of medication, if those other things haven't **worked**, but I don't know how you would **start** to know whether it is one or the other, I- I don't know. I'm not sure of the answer to that.
>
> 1(28): What I understood with what you said was um, that clinical depression is kind of **organic** disease? Which happens- Which occurs due to um a change in the **physiology** and the **anatomy** of the **bra:in**? But then uh the other thing that you said, that is more related to um… an **acute** sort of onset? [4(32): right] right? Where some life event, or

something which happened **outside**, **not** in the brain physiology, or anatomy, or biochemistry.

4(32): so like **mo::ving** [5(26): ya] to somewhere across [1(28): ya] the world

5(26): like situations that **cause** the [4(32): ya], **feel** differently, not so much [4(32): right] your actually makeup [1(28): yeah], it's like your **biology** [1(28): yeah], yeah

2(35): but I think it could **trig-** like, if you lose a **parent** [4(32): right], or you lose a **child** [5(26): yeah], that I think that **sa::dness**, it can, it's like a **feed**back thought, cause then your brain **ca:n** then switch [4(32): I agree], and it can become this **organic** thing [1(28): yes 5(26): mhm]. But I don't know if it **always** has to be, you know? You know, you said they can't take **blood**, but-
[1 Zoloft]

To place this excerpt in context, 5(26) just communicated an experience of moving far from home, which she associated with depression. 5(26) then brought to attention how she took part in certain behaviours, such as meeting new people and opening herself up to new experiences, as a means of getting well. Here the other participants are engaging with 5(26)'s description, in which some of the participants attempt to differentiate depression into situational and clinical depression – the communicated experience of moving is positioned as more situational than clinical. This effort towards differentiation works as an attempt to reclaim depression as something more severe than what this participant claims to have experienced, and as warranting medical treatment.

4(32), in particular, attempts to associate depression with medical expertise. The use of 'clinical' to differentiate depression, works to associate this 'type' of depression with the 'medical' through the use of medical terminology. 4(32) further specifies that clinical depression is something chemical, adding to the association that is made between clinical depression and medical expertise, as well as indicating a higher degree of severity. Finally, the participant specifies that "your doctor" can determine the difference between situational and clinical depression, additionally associating medical expertise. This medical association works to

emphasise the severity of depression through association, and to minimize 5(26)'s communicated experience through contrasting it with clinical depression.

Depression is also reclaimed as something severe and serious through locating it as something that reduces one's agency and necessitates medical treatment. For example, 4(32) argues that she "think[s] sometimes you can make those changes [e.g., open yourself up to new experiences], but sometimes that's not enough, so you have to have the added thing of medication, if those other things haven't **worked**." There is an acknowledgement that one might be able to take agency in the context of depression, but that there are also severe experiences in which one cannot take agency or control without the addition of medication. The sentiment that is communicated is similar to, 'one does not just take medication because one does not want to put in the effort, but because one is a victim of one's biology'. As such, depression is positioned as something severe and serious through this association with a lack of agency and control.

Though the positioning of depression as purely medical is troubled by other participants, its severity is still indirectly reified. For example, 2(35) states "if you lose a **parent** or lose a **child**, that I think that **sa:dness**, it can […] cause your brain **can** then switch, and it can become this **organic** thing." In this excerpt the participant makes reference to experiences that are relatively severe (e.g., 'the death of a parent or a child') - extrematization. As such, even if 4(32)'s reliance on a medical distinction falls short and is undermined itself, depression is still distanced from being minimized and normalized and in a sense partially reclaimed. Further, though 1(38) acknowledges that there might be a more complex relation between situational and clinical depression, she argues that the situational "could" lead to something medical - she does not refute the idea that there might be depression that is purely medical.

3.2.3 Summary

In summary, in interacting with the presentation of depression and treatment within the advertisements, the women frequently reclaim depression as an experience that is specific, severe, serious, uncommon, and separate from normal. This reclamation takes place in the context of undermining the ad's claims to depression, and through the presentation of the participants' own claims. These claims by the participants often take the form of counterclaims to those presented within the advertisements. More specifically, the advertisements are directly or indirectly indicated as insufficiently differentiating depression from alternative experiences and, as a consequence, trivializing, downplaying, oversimplifying, and/or confusing depression.

3.3 Reclaiming Normal

On various occasions, in interacting with the advertisements, the participants attempt to clarify and rigidify a distinction between 'normal' experiences and pathological experiences, including depression, distancing these 'categories' of experiences from one another and thereby reclaiming normal. Normal here is deduced from the participants' positioning of experiences as general, universal, or common. The women both directly and indirectly construct ways in which the ads blur the line between normal and depression or pathological experiences. The implied claims to normal made by the advertisements are troubled and undermined using various linguistic resources. This undermining is frequently paired with the women directly and indirectly staking their own claims to the category. It is within this combined refutation and counter-claim that are found the attempts at distancing normal experiences from being positioned as pathological, as well as the reclaiming of normal.

Some participants engage directly with how depression is presented within the advertisement, and emphasise the ways in which it provides insufficient differentiation. Other participants engage more closely with the presentation of treatment, emphasising that the treatment does not fit the presentation or is inappropriate. Within these various discussions of content, the participants employ such mechanisms as normalization, abnormalization, minimization, and extrematization. For example, reference is made to experiences as grief and sadness, stress, general hurting, lacking energy, feeling bad, or a general lack in productivity. These states are often downplayed or trivialized in such a way as to emphasise their universal or normal nature.

3.3.1 Depression

The first quote illustrates how a participant critically engages directly with the presentation of mental illness and depression within the advertisement, and very explicitly and directly qualitatively (pathological vs. normal) distances normal from them.

> 1(28): ya::, and it's really not- it is really leaving the borders **blurry** of what is actually mental **illness,** and what is just like.. **life**, do you know what I mean? cause sometimes life is **crappy**, it doesn't mean that you are **depressed**, like are you going to feel bad sometimes, **yeah**, it might even **last** for a couple weeks, you know, someone **dies**, there is **grief**, it doesn't mean you are **depressed**, even though they took that out of the DMS,

that is what I have to say about that, but, do you know what I mean, so it is making these things that are really.. sort of like the symptoms of the human **condition** and **pathologizing** it [C: mm], you know, to a greater extent than it **should** be, because I-don't get me **wrong**, I believe depression is **very** re:al? But I mean, I think they'r::e… **targeting** it to people who don't necessarily **have** it, if that makes sense.
[5 Cymbalta]

1(28) starts by problematizing the presentation of normal within the advertisement. She argues that the ad, "is really leaving the borders **blurry** of what is actually mental **illness**, and what is just like… **life**." Further, the use of 'really' here works as a form of extrematization that supports the undermining of the ad's claims to normal ('life'). The participant specifically says "it doesn't mean you are **depressed**," and that the ad was "**targeting** it to people who don't necessarily **have** it." As such, there is a critical engagement with the advertisement in which the participant emphasises that the advertisement falls short in making this distinction between mental illness and life, a distinction that is implied to exist and as important (an importance implied by the highlighting of its absence).

The participant's critical engagement with the advertisement is further evidenced by her bringing to attention potential intentionality in the ad's claims. For example, she constructs the ad as 'targeting people'. As such, the ad is subtly positioned as having a vested interest in its implied claim (e.g., it is not objective 'truth').

Focusing specifically on the use of normalization that is used to reclaim normal, the participant argues that "it [the ad] is making these things that are really.. sort of like the symptoms of the human condition and pathologizing it […] to a greater extent than it should be." Here it can clearly be seen that there is a reclaiming of 'normal' through invoking the general and universalized notion of the 'human condition' (normalization) and how it is 'pathologized' within the advertisement. As such, the distance between normal and pathological is reiterated through highlighting and critically engaging with its absence.

The participant also makes reference to temporality as a means of further reclaiming normal. Specifically, she elaborates that "it [feeling bad or crappy] might even **last** for a couple weeks." This explicit bringing to attention of temporality suggests a risk of feeling bad or crappy over an extended period being positioned as pathological; the use of 'even' brings to attention

that it might not otherwise be thought that one *can* feel bad for a couple weeks without being depressed. This reference to temporality is also a potentially implicit resistance to dominant psychiatric discourse – there is not only resistance to the ads specifically, but dominant psychiatric discourse more broadly. As such, normal experiences of 'feeling bad' or 'crappy' are further distanced from mental illness, through emphasising that not only are the experiences normal if they are experienced in a moment, but even over time.

The following excerpt provides an example of a particularly interesting interaction in which the participant compares the advertisement to one that was previously shown to the focus group, and she engages directly with temporality.

> 2(51): this one didn't put a time line on it, which was interesting, do you know, that if you have been sad for a couple weeks? [C: mm] kind of? like the other one? and it is for example if you look at if we lose someone, and we're- we're in grief, do you know [C: mm], we can be in grief for two weeks, a month, a year, do you know, like, every anniversary of, you know, birthdays or whenever you think of them and you're sa::d, you know, and we may be sad that we won't walk the dog today, but it's a sporadic thing? you know? so this one isn't kind of putting me in a box and saying if in two weeks, you know, you're depressed (small laugh) [1(38): ya] [3(37): ya] you know, it's not just.. things aro:u:nd you, it is like, do something [C: ya]… kind of like a call to action, and this one was, you know, it didn't.. put me… pressure to [3(37): mhm] deal with it
>
> 3(37): yes
> [4 Cymbalta]

The participant makes reference to temporality in a way that emphasises a qualitative difference between 'normal' and depression in reclaiming sadness and grief over an extended period of time, from being positioned as pathological. First, the participant references specific experiences of sadness and grief rather than saying depression (normalization and minimization). Beyond stating that this normalized grief or sadness might be experienced for a 'long' period of time after 'losing someone,' she also argues specifically that there might be 'good reason' to experience such grief over a long period of time – due to memory, and such events as

anniversaries. This provision of cause provides a justification for why long term grief might not be depression or pathological. In this case, there is a reclaiming of normal as something qualitatively different from depression through pulling on notions of temporality.

Further, the participant's specific resistance to grief over a 'two week' period being positioned as pathological may be an implicit reference to psychiatric diagnostic discourse; this reference works as potential resistance to this discourse's claim to normal – the two-week diagnostic criteria for depression.

The participant supports her counter-claim to normal through further undermining the claims of the previous advertisement in her elaborated reference to temporality. In comparing with the previous advertisement, the participant states that the ad "didn't put a line on it […] this one isn't kind of putting me in a box and saying if in two weeks, you know, you're depressed (small laugh) […] kind of like a call to action […] it didn't.. put me… pressure to deal with it." In contrast it might be assumed that the previous advertisement 'does put a line on it and says that in two weeks you are depressed, and it put pressure to take action'. This saying has a negative connotation, such as confining or restricting in some way, and therefore positions the previous advertisement, the one that does 'put a line on it,' as 'putting one in a box'. This negative positioning provides space for her counter-claim to normal.

In contrast to the previous examples, some participants do not directly engage with depression as a category. Rather, they focus more on normalizing the presentation in the advertisement.

> 4(38): I thought it was just like, ya, every**day** doesn't everybody have to **wi:nd** themselves up to like sometimes go to **work** or do the next **activity** anyway::ys? So it was just kind of **general** I think, you know, you don't want to do things but you **h:a:ve** to because that is **life**, so you just **wind** yourself up, even if you are **not** depressed [inhale] [C: mm]. Ya, it was like an **energy** thing **right?** [5(41): ya] Ya:
> [6 Pristiq]

Here the participant attempts to undermine the presentation of normal in the advertisement, and to stake her claim to the category. Normalized experiences are distanced from being pathologized through the ways in which the advertisement is argued to fall short. For

example, 4(38) says, "every**day** doesn't everybody have to **wi:nd** themselves up to like sometimes go to **work** or do the next **activity** anyway::ys? So it was just kind of **general**." Not only is what is presented in the ad experienced 'everyday;' it is also experienced by 'everyone' (normalization and extrematization). Further, she states "just kind of **general**"; through the use of 'just' there is a minimization of the subsequent thing being described, the 'general'. Further, there is also reference to normalized and minimized experience in reference to work, and a lack of energy.

Looking at the communication of notions of productivity, a further normalization of the presentation of depression within the advertisement is highlighted. The participant makes specific reference to notions of productivity in noting a need to wind one's self up (a metaphor used in the advertisement) to "go to **work** or do the next **activity**." The reference to needing to wind oneself up for the 'next activity' is particularly interesting in the way it leaves open the potential to acknowledge that a lack of productivity in any task or activity – even those that are enjoyable – can be 'normal'. She also remarks that "you don't want to do things but you **h:a:ve** to because that is **life**, so you just **wind** yourself up, even if you are **not** depressed." Again there is a reclaiming of 'normal' experiences of lack of productivity.

3.3.2 Treatment

In this next excerpt, there is a reclaiming of normal through the differentiation of depression from sadness and stress, in the context of engaging with how the experience might be treated. Here, the participants reclaim 'normal' by discussing a rejection of the medicalization of stress or sadness.

> 1(28): I guess a person::?... u::m who is::- would have some **stressor** or some sort of other, maybe for a **week,** or 5 days, or he is feeling **sad** for five days, after seeing this thing, he **mi:ght** think that… he needs to take some medi**cation,** or he won't **get over** it without the medication? [4(32): ya] I- I think that's- that's… not… that's not **fa:i:r** –
>
> 4(32): - I think that **should** be included, that [1(28): ya:] **time** frame, because there is a **time** frame
>
> 1(28): ya … …

[1 Cymbalta]

1(28) remarks that an individual who experiences "stressor[s]" or "sadness" "might think that he needs to take some medication, or he won't get over it without medication," and that this is "not fair." Reference to stress and sadness works to associate the presentation in the advertisement with common experiences. Further, saying that it is "not fair" that treatment of sadness and stress would be medicalized emphasises the distance between experiences that are positioned as pathological and normal. What's more, 1(28) implies that stress and sadness could be something that one could simply 'get over without medication'.

Further, the participants say that the ad positions medication as necessary in the context of such experiences as "sad[ness]," and are critical of this positioning. As such, there is an assumption that in the context of experiences of stressors or sadness one often has some amount of agency to 'get over it'. Medication, on the other hand, is positioned as taking away that agency (e.g., not being able to get over it without antidepressants). Here, the ad is positioned as implying that the individual who is stressed or sad does not have agency, but rather needs medication. The participants provide a vigorous counter-argument, reiterating that the sad or stressed individual is not an agentless 'victim' or 'patient,' but rather is an 'agent'. It is implied that the ad is abnormalizing normal experiences through medicalization, and the participant works to undermine this abnormalization through critical engagement and subtle claims about what constitutes normal.

In this next excerpt the participant distances normal from depression through reference to treatment, but in a much more subtle way than in the previous excerpt. Particularly interesting is the way that the participant normalizes the presentation in the advertisement and then subtly brings to attention the absurdity of the presentation being associated with medical treatment.

> 2(51): I think there's a **lot** more **to**, you know, **happy sad** in our **life**, so for that period of **time**, do you know, there's.. **many things** feeding **into** that? do you know? Sometimes? that just to just feel sad for two weeks is I need a drug, you know, it says I need a drug. [4 Zoloft]

The participant normalizes and minimizes the presentation in the ad in her references to 'sadness'. This choice to reference sadness instead of depression works as a form of normalization and therefore positions the ad as abnormalizing normal experiences. Further, tying this sadness to the situational, she states that "there's.. many things feeding into it [the sadness]." Elsewhere this participant discussed how such experiences as grief, after the death of someone one knows, is not necessarily depression. If this addition of context is taken into account, the reference to "many things feeding into it [sadness]" can be considered as similar in nature to this participant's other communications – e.g., if someone one knows has died and one is sad, this death might be feeding into the sadness. As such, this positioning of the experience as situational connotes a potential plausible cause, further normalizing the referenced experience. Further, the use of *just* works to downplay and normalize, if not trivialize, sadness, specifically sadness experienced for two-weeks.

The participant positions as absurd the medicalization of 'situational sadness for *just* two weeks,' in the comment "just feel sad for two weeks is I need a drug, you know, it says I need a drug." By combining the phrases '*just* sad for two weeks,' and "it says I need a drug," there is the communicated sentiment 'it is saying I need a medication for something that is just sadness' - problematizing and normalizing the medicalized claims to the experience in the advertisement, the participant troubles the ad's claim to normal, and reifies the presented experience as normal.

In this next and final excerpt for this category, rather than simply saying that the experience in the advertisement does not warrant antidepressant treatment, as others do, these participants specifically reference a normalized way that the experience might be treated.

> 1(28): it doesn't fit for me at **a:ll:**, like it- it **really** doesn't, I think that's- that's r- be **somethin:g:** you would give if you're advertising those 24 hour energy drinks or whatever they are, you know what I mean [3(23): (laughs)], like kind of like you are just **tired** and don't want to [3(23): ya]- but for **depression** it is **no:t**, its- **ya**, **right!**-
>
> 3(23): - like you don't have **energy and**- or you don't **want** to do something then you have to **make** yourself to do something [1(28): ya:], it's like winding up, you just [someone laughs] [1(28): ya] like, ok, I have to clean up my **house** [1(28): ya (laughs)], ok (laughs) I just have to **go** and **do** that

1(28): you don't need an **antidepressant**, you need a cup of **coffee**, like (laughs) it's just, I don't know… out of touch from what **I** would think.
[5 Pristiq]

In this excerpt, the participants are very explicit in noting that the advertisement falls short in reflecting how they position normal. Specifically, on several occasions the participants communicate that the advertisement does not fit with how they view depression (and through contrast, normal): "it doesn't fit for me at **all**, like it- it **really** doesn't," "but for **depression** it is **not**," "you don't need an **antidepressant,** you need a cup of **coffee**," and "out of touch from what **I** would think." Note the use of extrematization: "not at **all**," "out of touch," and "**really** doesn't"; rather than just saying 'it does not'. Here the participants highlight and emphasise the difference between how they position experience, and the presentation within the advertisement. This emphasis on the disconnect sets the tone for the subsequent reclaiming of normal, as it brings into question the veracity of the ad's implicit claim to normal.

First, there is a clear positioning of the referenced experiences (a lack of energy) as 'normal' through reference to how the experiences would be addressed – an energy drink, a coffee. It can be assumed that this reference to normalized and minimized treatments implies the treatment of common experience.

Second, if looking now at the reference to 'doing what you need to do,' there is a positioning of the 'not being able to do what you need to do' as a reference to choice or something under personal control. The positioning of a lack of productivity as under one's control situates it as an issue of choice, which relates more to character (e.g., laziness) than pathology.

Finally, there is a reclaiming of 'normal' from pathologization if the implications of the mentioned treatments are considered- 'if I don't want to clean my house or do not have energy, that does not mean I am depressed, it means that I need to take responsibility and force myself to do it, or have a coffee or energy drink'. As such, the presentation in the advertisement is brought into critical light.

Through bringing to attention that the ad abnormalizes experiences that are very normal, the participants attempt to undermine the ad's claim to these experiences as abnormal. In the

context of this refutation, the participants provide an implicit notion of normal, and distance it from pathological.

3.3.3 Summary

In summary, many of the participants, in various ways, attempt to reclaim normal from pathologization. Some participants distance these categories of experience through engaging with how depression is presented within the advertisements, while others engage more closely with the depiction of treatment. Further, some participants are very explicit in their critical engagement with the advertisements and reclamation of normal, while others are more subtle. The reclamation of normal takes place in the subtle undermining of the ads' implicit claims to normal, and the provision of counter-claims to the category by the participants. These counter-claims usually take the form of reification of the experiences in the ads as normal while questioning their being positioned as abnormal. As such, though there are variations in their claims to normal, most participants use some sort of normalization and minimization of the presentation in the advertisements as part of their efforts to reclaim the experiences as normal.

3.4 Caution in and Defence of Claims: The Introduction of Ambiguity

In the context of attempts at differentiating depression and normal, in efforts to clarify and reclaim the categories, the participants often leave the categories themselves relatively 'blurry' and 'open,' whether directly or indirectly. This use of systematic vagueness takes place both in the context of reclaiming depression and normal, and takes various forms. According to Potter (1996), the use of systematic vagueness can work in a way, similar to a defensive rhetorical device, which makes a claim or description more difficult to undermine. This presentation of ambiguity also introduces complexity into the notion of what might be at risk for the women in critically engaging with the advertisements and each other.

There are many ways in which the women use systematic vagueness in their reclaiming of depression and normal. Structurally, various forms of hedging introduce ambiguity into efforts to differentiate the categories. For example, the first person is often used in such a way that leaves the category of depression open to alternative interpretation. Further, uncertainty about the category of depression is also introduced through paralinguistic cues and language choice, e.g., hesitations, vague statements, and the use of 'I don't know'.

Much of this ambiguity is done in the context of engaging with notions of degrees of severity, comparisons between depression and alternative experiences, and/or engaging with

notions of types of depression. Rather than saying that the depression in the advertisement is not depression, the notion of degrees of severity, for example, allows the participant to acknowledge the 'milder' experiences as depression, while also simultaneously reclaiming depression as something severe, serious, and uncommon, defending their claim through not fully refuting other claims. Though the systematic use of vagueness might be positioned as supporting a claim through making it more difficult to undermine, it also evidences a propensity toward caution when engaging with the constructs of depression and normal.

Because some of the excerpts in this section have appeared in the previous sections, the focus here is on bringing to attention the systematic use of vagueness rather than reiterating the context of reclamation of normal and depression within which this vagueness occurs.

3.4.1 Types

In this first excerpt there is an introduction of ambiguity and use of systematic vagueness in how the participants engage with notions of 'types' of depression.

3(18): Or just like **sa:d**, **unhappy**

4(26): [which everybody can **be** too, like (laughs)

3(18): and you know, good things are happening it] was just like you are not in a **good mood** basically

5(29): Yaa, to me it kind of looked li::ke this is our portrayal of mild depression::, or maybe just dealing with things like grie:f: or sad- general sadness or whatever [2(26): ya::] but, ya, it jus- to me::, I don't know.. I- I'm su:r:e it can market it to a lot more people this wa:y? But ya…

2(26): that- that's true, nothing is depression specific, like, you know:, these symptoms, the sa:dness and- you can be sa:d at a birthday party, you can [5(29): (laughs)], [4(26): like it's ok], [general laugh] these=

3(18): =it's like, it is implying that every little thing is like clinical depression

2(26): ya, exactly! [General laughs]

3(18): [there's a big difference (laughs)
[2 Cymbalta]

In this excerpt, 5(29) brings in the notions of types of depression (clinical), which introduces some complexity and ambiguity into the discussion. For example, she states "this is our [the ad's] portrayal of mild depression::." Though there is a clear positioning of the advertisement as presenting something that is less serious/severe and more common (exemplified in the normalization of the presentation) than "clinical depression," arguing that the presentation may be of 'mild' depression leaves open a space for these 'normalized' or less severe experiences to be acknowledged as depression, though perhaps not clinical. As such, the distancing of normal and depression becomes further muddled rather than clarified.

Further, some participants use various forms of hedging in their discussion, which works to further leave open the categories of depression and normal. Through bringing to attention that the communication is an opinion, the participants leave open space for alternative understandings. For example, 5(29) constructs her claim as being her 'opinion,' such as through noting "to me it kind of looked like" and "it jus- to meee, I don't know." What's more, there is also hesitation in this critical engagement with the advertisement. For example, she says "it kind of looked like," "or maybe just dealing with things like grief," "I don't know" and there is a questioning tone following "people this way." Such things as 'kind of,' 'maybe,' and 'like' work as hedges that allow flexibility for alternative interpretations - participants are not making absolute statements, but rather structuring the statements in a vague way. As such, the women both simultaneously emphasise the line between depression and normal while also blurring that line through hedging and uncertainty.

In this next excerpt, the participants engage more directly with the notions of clinical depression. More specifically, they attempt to distance clinical depression from situational depression.

4(32): =I think there's a difference between **situational** depression and like **clinical** depression [5(26): ya], and that's where the **chemical** part came in [5(26): ya] cause I think there's definitely a distinction there, and your doctor can help you determine that. C: I wonder if maybe you could- or, if we together could elaborate on that distinction as well … […]

4(32): um, well I guess cause it's not like the doctor can draw blood and say 'well you're depressed'. It is still based on … what you are saying your symptoms are. But I know, with my doctor it was kind of like, 'well have you had any recent life events that could be contributing to this' and kind of **probing** a little bit more? So I don't know …. I don't know, I don't know how you would actually make that distinction in words. I know that, I think sometimes you can make those changes, but sometimes that's not enough, so you have to have the added thing of medication, if those other things haven't **worked**, but I don't know how you would **start** to know whether it is one or the other, I- I don't know. I'm not sure of the answer to that.

1(28): What I understood with what you said was um, that clinical depression is kind of **organic** disease? Which happens- Which occurs due to um a change in the **physiology** and the **anatomy** of the **bra:in**? But then uh the other thing that you said, that is more related to um… an **acute** sort of onset? [4(32): right] right? Where some life event, or something which happened **outside**, **not** in the brain physiology, or anatomy, or biochemistry.

4(32): so like **mo::ving** [5(26):ya] to somewhere across [1(28): ya] the world

5(26): like situations that **cause** the [4(32): ya], **feel** differently, not so much [4(32): right] your actually makeup [1(28): yeah], it's like your **biology** [1(28): yeah], yeah

2(35): but I think it could **trig**- like, if you lose a **parent** [4(32): right], or you lose a **child** [5(26): yeah], that I think that **sa::dness**, it can, it's like a **feed**back thought, cause then your brain **caan** then switch [4(32): I agree], and it can become this **organic** thing

[1(28): yes 5(26): mhm]. But I don't know if it **always** has to be, you know? You know, you said they can't take **blood**, but-
[1 Zoloft]

Relying on a distinction between clinical and situational depression allows 4(32) to be positioned as not potentially refuting another's communicated 'milder' experiences as being depression. As such, this use of language also allows the defence of the reclamation of depression. More specifically, pulling on notions of situational vs. clinical depression, 4(32) is able to acknowledge a broad range of experiences as depression, which allows her to defend the claims to depression as severe and serious – she is not entirely undermining other claims to depression, which helps defend her claim from being undermined through invoking further counter-claims. As such, through leaving depression relatively open through pulling on notions of situational and clinical depression, 4(32) evidences an attempt to defend the claim to depression as severe and serious, and a caution in engaging with the category.

4(32) similarly uses vagueness to defend her claims to depression and evidence caution in staking claims to the category. 4(32) claims, "sometimes you can make those changes," in reference to 5(26)'s communication about getting well through such things as taking agency and being open to new experiences. The reference to 'sometimes' works to make the above statement vague. This vagueness both allows for an acknowledgement of experiences of agency in the context of depression while defending claims to depression as also a lack of agency and therefore severe and serious.

Additionally, there is clear uncertainty in the distinction, as in the use of such phrases as "I don't know." This uncertainty works to leave the category relatively blurry, despite claims to the severity and seriousness of depression. At the same time, this use of 'I don't know' can work to reduce the likelihood of disagreement, as the claim is made much more tentatively and cautiously.

At the same time, the use of this biomedical distinction falls short for 4(32) in terms of defending her claims to depression. First, note the clear attempts, particularly by 4(32), to associate depression with biomedical expertise. The positioning of depression as something distinctly medical, in contrast to minimized situational depression, is problematic; the participant acknowledges that one cannot objectively draw blood (a practice associated with medical

expertise and objectivity) to test for depression. This acknowledgement troubles the positioning of depression as purely medical, which works to at least partly undermine her claims to depression. This falling short is further reiterated in 4(32)'s struggling attempts to articulate in further detail the differentiation between clinical and situational depression.

Through engagement with each other, the participants further trouble the differentiation of depression as either situational or clinical. 2(35) troubles the positioning of depression as purely biological through noting "if you lose a **parent** or lose a **child**, that I think that **sadness**, it can […] cause your brain **can** then switch, and it can become this **organic** thing." Here the positioning of a difference between situational and clinical depression is made uneasy. This demise of the line between situational and clinical works to undermine 4(32)'s attempt to simultaneously close off and leave open the category of depression.

3.4.2 Degrees of severity

There are also instances in which participants rely on general notions of degrees of severity of depression. Engagement with degrees of severity of depression takes place mainly in the context of reclaiming depression. In this next excerpt the participant employs notions of degrees of severity of depression in her reference to mild depression.

> 1(38): […] um, but I d- I t- I- ya::, I- I think it is **possibly** um a representation of **mi::ld** depression, like a one **event** depression, something, [C: mm] not like **long** term thing, more like, you know, your dog has just **di::ed** and you might be a bit **depressed** and it is something to kick you **up**, maybe a **single.. episode** u:m, I think it's possibly more accurate for **that** than a long.. term um **medical** issue really
> [4 Zoloft]

The use of degrees of severity here (mild to descriptively more severe) works as a hedge in discussion of and claims to depression. More specifically, rather than saying that the presentations of depression within the advertisement are *not* depression, she remarks that they might "**possibly**" be a "representation of **mild** depression." This positioning of depression allows the participant to question the presentation of depression within the advertisement, without positioning herself as necessarily questioning alternative experiences or understandings of

depression. As such, her claims to depression are defended through not encouraging reactive counter-claims.

Further, the participant uses various forms of hedging, such as the first person, to defend her claims and introduce caution. For example, the participant uses the phrasing "I think" on a few occasions, which brings to attention that her communication is an 'opinion,' rather than 'fact'. This positioning of her communication as subjective leaves space for alternative claims to be acknowledged as valid, as well as for disagreement through introducing the notion of stake – her interest in the claim is brought to attention subtly here. As such, though the participant attempts to reclaim depression through differentiating it, she also simultaneously leaves that distinction open and ambiguous. This ambiguity makes her claim to depression as severe and serious more difficult to undermine (defensive rhetoric), as well as demonstrates caution in engaging with the category of depression.

In this next excerpt the participant employs more subtle notions of degrees of severity of depression by contrasting the presentation in the advertisement with more 'profound' depression.

> 3(55): um… it was too:: **simple** to me for- to be connected to the people that I know [C: mm] that have dealt with depression. Um… and I mean, i- i- the- obviously there is different.. **levels** probably, of depression as well, but, [C: mm] somebody… like, whenever I have been around someone who is been **profo:u:ndly** depressed, they can't… I mean, they- I don't even think that would **register** as a- it's like- it's all consuming, it is not like it is something that is separate really it is just [C: mm] 'this is who I am, this is… this is the way it is, this is my **reality** right **now**,' so I don't **know** that, like I said again, I feel like it would be- it is an easier thing for someone to understand that is **not** depressed? if you look at it that way [C: mm] um.. I don't know
> [6 Zoloft]

While the participant reclaims depression as something serious and 'profound' (contrasted with the presentation in the ad), she does so without rejecting the existence of experiences of depression that might be less severe or 'simpler'. For example, after noting that the presentation within the advertisement is 'too simple,' opening up the presentation to being positioned as not depression, the participant states "obviously there is different.. **levels** probably,

of depression." This reference to the possibility of 'levels' of depression works to leave open the potential acknowledgement of a 'simpler' or less 'profound' experience of depression as still being depression. As such, the reference to degrees of severity works to introduce vagueness and defend her claims to depression as 'profound,' as well as reveal tentativeness in making claims to depression.

Further, the positioning of 'knowledge' as obtained through close experience with depression leaves open the category of depression to alternative 'interpretations,' as well as provides category entitlement. For example, the participant states, "people that I know that have dealt with depression," and "whenever I have been around someone who has been **profo:u:ndly** depressed." The reference to personal experiences here hedges discussion. In noting "whenever I have been around," there is space left open for the participant's experience with depression to not fully encompass depression. For example, perhaps people she knows with depression are different when she is not around them. At the same time, this use of vagueness introduces a space for alternative claims to depression to be acknowledged without her claim to depression necessarily being undermined completely. Further, the reference to close personal experience with depression provides a defence of her claims to depression through the mobilization of category entitlement. For example, someone who has personal experience with depression, even if not having been depressed him/herself, can be seen as more entitled to make claims to depression, as s/he is not speaking from a complete lack of experience. As such, the participant introduces vagueness here, which allows her to further defend her claims to depression in a subtle way, as well as tentatively engage with depression.

In the final example for this section, the participant references degrees of severity through engaging with notions of mild and slight depression, as well as 'extremes'. Though the participant uses some similar resources as previously mentioned, she also uniquely locates responsibility for her claims.

> 1(38): again like it did feel like it was, you know, it was just like **slight** depression, I think these are all **targeting..** just like, uum, I don't know what the different levels are **ca:lled**, but it is jus:t sort of **mi::ld** depression isn't it, you know, [C: mm] it's like the woman just didn't want to take the **dog** for a walk, you know, it's not like kind of extremes that you have been **talking** about (indicates towards 2(51)), so I think a lot of

these pills are just- it is **aimed** at people with **mi::ld** depression, I don't know how well they get that **across** in the **a::dvert**, but that seems to be what they are **a:i:ming** for. [4 Cymbalta]

As evident in previous excerpts, the participant uses the first person in such a way that leaves space for alternative ways of making meaning of the advertisement and depression. She also uses phrasings that introduce uncertainty in regard to what depression is. For example, 1(38) brings to attention that she is talking from the 'subjective' through the use of such phrases as "I think." Further, uncertainty is introduced in such references as "I don't know what the different levels are called" and "it is just sort of mi::ld depression." There is uncertainty in the communication of degrees of severity ("I don't know"), as well as in an ambiguous reference ("just sort of") to 'mild depression'. This hedging introduces some level of caution in critical engagement with the advertisement and staking claims to the categories, defends her claims from being undermined, and allows for the acknowledgement of a range of experiences as depression.

However, unlike in previous excerpts, this participant uses the allocation of responsibility for a communication in such a way that introduces caution in and supports her claims. Though this participant elsewhere references 2(51)'s communication of 'extremes' as something that would possibly 'be interpreted as something other than depression,' 1(38) here employs this notion of extremes in such a way that allows a hedging and defence of her own claims. 1(38) distances herself from the communication of depression as having 'extremes,' through bringing to attention that the notion of extremes is taken from 2(51) – this reduces her responsibility to the claim and evidences caution in staking a claim to the categories. At the same time, through bringing to attention that something 2(51) said is in line with her own communication the participant builds a sense of consensus – it was not only her own opinion that the ad presents mild experiences, but rather a claim that is implied as shared (see Potter, 1996 for further discussion of the use of consensus). As such, this bringing to attention that the communication is in line with what 2(51) said can also work to defend the participant's claim from being undermined, as well as evidence caution in staking claims.

3.4.3 Alternative experiences

In distancing depression from alternative experiences, as opposed to different types or degrees of severity of depression, ambiguity or vagueness is also evident, as exemplified in the following excerpt.

> 1(28): ya::, and it's really not- it is really leaving the borders **blurry** of what is actually mental **illness,** and what is just like.. **life**, do you know what I mean? cause sometimes life is **crappy**, it doesn't mean that you are **depressed**, like are you going to feel bad sometimes, **yeah**, it might even **last** for a couple weeks, you know, someone **dies**, there is **grief**, it doesn't mean you are **depressed**, even though they took that out of the DMS, that is what I have to say about that, but, do you know what I mean, so it is making these things that are really.. sort of like the symptoms of the human **condition** and **pathologizing** it [C: mm], you know, to a greater extent than it **should** be, because I- don't get me **wrong**, I believe depression is **very** re:al? But I mean, I think they'r::e… **targeting** it to people who don't necessarily **have** it, if that makes sense.
> [5 Zoloft]

The participant hedges her discussion of and critical engagement with the advertisement through the use of various forms of systematic vagueness. For example, she says that the ad "pathologiz[es] it [the human condition] to a greater extent than it should be." The use of "than it should be" introduces vagueness that further leaves open the categories of both depression and normal, despite her claims to the categories. For example, this vagueness brings up the question of the extent to which the human condition should be pathologized, and reintroduces a blurred distinction between 'normal' and depression. Finally, the participant also introduces uncertainty in saying "sort of like the symptoms of the human condition." Again the use of vague or ambiguous statements ("sort of like") to position depression and normal can be seen. As such, this vagueness allows the participant to both make claims to the categories, while making refutation of her claims rather difficult, as well as evidence caution in staking claims.

The participant also positions some of her statements as explicitly subjective. For example, she says "that is what I have to say about that." This phrase leaves space for others to 'say' something different without it necessarily completely refuting her claim.

The reclaiming of normal itself is further hedged. For example, following her critical engagement with the advertisement, the participant states, "don't get me wrong, I believe depression is very real." Here the use of 'very' is a form of emphasis placed on the hedge through extrematization. This statement works as a hedge against the participant being positioned as refuting the existence of depression, which might have undermined her own claims to normal. At the same time, it reveals a caution in critically engaging with the category of depression. That is, there is a risk that she might be positioned as refuting the 'reality' of depression due to her reclamation of normal.

3.4.4 Summary

In summary, participants' linguistic attempts to reclaim depression from being trivialized, as well as normal from being pathologized, often occur in the context of the use of systematic vagueness. Specifically, the women use various linguistic resources, e.g., the positioning of communications as subjective, the introduction of uncertainty, and the use of vague open-ended statements, to introduce ambiguity in their attempts at differentiation and reclamation. This ambiguity is also evidenced in the context of the participants' attempts to differentiate types and degrees of severity of depression, as well as depression from alternative experiences, such as normal. This introduction of ambiguity works to maintain a blurred definition of depression and normal, as well as a blurred distinction between depression and alternative experiences, despite claims being made to the categories. As such, despite critical engagement with the advertisements, in which the advertisements are often positioned as insufficiently differentiating the specified categories of experience, the women themselves both push back against and maintain this lack of clarity. This use of vagueness reveals that there might be risk in engaging with the categories of depression and normal, as well as a defence of claims to these categories.

3.5 Summary

In this chapter I explored how women interact with and make meaning of the messages in direct-to-consumer antidepressant TV advertisements through looking at the data from the current research project. Through mobilizing Potter's (1996) use of rhetoric, the analytic categories identified and discussed include *Reclaiming normal*, *Reclaiming depression*, and *Caution in and defence of claims*. These categories were clarified through the use of excerpts taken from the data set which exemplified the specific categorized speech actions. More micro

speech actions were discussed in the context in which they helped complete the larger speech actions categorized above.

CHAPTER 4
DISCUSSION AND CONCLUSIONS

4.1 Introduction

In this final chapter, I contextualize the results discussed within the previous chapter. I will discuss each of the analytic categories in term, as well as attempt to bring the research findings into a dialogue. As such, I conclude with a discussion of overall conclusions, the potential significance of this research and research like it, and potential future directions.

An overarching finding was that the women do not simply unproblematically take up or mobilize the presentations, particularly those related to mental health, of the advertisements. This conclusion is in line with current literature that discusses how the public engages with health information more generally (Lock, 2012). Specifically, it has been identified that the public does not simply take up health information, but rather integrates it with other available ways of knowing and discourses (Lock, 2012). As such, it would be expected that the women would not simply imbibe the discourses related to depression within the ads, but engage with them in a complex way.

What is of particular interest is the ways in which the women are critical, and what this accomplishes. More specifically, through focusing on how the women use language to complete particular actions I demonstrated how the women critically engage with the ads' claims in such a way that undermines them, opens a space for their own claims, and allows them to stake and defend counter-claims. Rather than simply focusing on the women being critical of the ads, a detailed look at language use allows us to see how both "normal" and "depression" seem to be threatened by the ads, as well as how there is a demonstrated caution in engaging with claims to these categories. Looking at the women's use of talk it can start to be identified how the ads, without assuming that they depict a particular presentation or have a particular impact, might not provide a particularly helpful way of knowing. This look at language also provides potentially valuable information in regard to the discourses the women have access to and use to engage with the ads – which ways of talk are particularly influential in how they interact with the ads, how meaning of them is made, and how this use of discourse is mobilized.

4.2 Reclaiming Normal

As noted, within the context of engaging with the advertisements, the women often use various rhetorical moves to undermine the implicit claims to normal of the ads, and they often

then provide counter-claims to normal. As such, there seems to be a threat to normal when interacting with the advertisements. The women's specific reclaiming of normal might evidence an access to circulating discourses surrounding medicalization and disease mongering (e.g. Applbaum, 2006; Arney, & Menjivar, 2014; Conrad, 1992, 2005; Healy, 2006; Heath, 2006; Kumar, Deoker, Kumar, Kumar, & Hegde, 2006; Lexchin, 2006; Mintzes, 2006a; Moynihan, Doran, & Henry, 2008; Moynihan et al., 2002; Shankar & Subish, 2007; Tiefer, 2006; Moynihan & Henry, 2006 as cited in Wolfe, 2006). Further, the women's potential accessing of medicalization and disease mongering discourses might be an indication that academic discourses on these issues are accessed beyond academia and might influence public discourses.

Medicalization and disease mongering, two related but different concepts, have been widely discussed in the context of mental health and illness in general and depression specifically, as well as discussions of DTC drug ads (Arney, & Menjivar, 2014; Conrad, 1992, 2005; Healy, 2006; Moynihan et al., 2008; Moynihan et al., 2002). Medicalization generally refers to a broad range of tactics to position an experience previously not considered medical within the domain of medicine, though there are multiple nuances in more specific uses of the concept (Conrad, 1992, 2005). Disease mongering refers to broadening of the boundaries of illness to maximize market profit (e.g., profit for pharmaceutical companies; Moynihan et al., 2002)

Originally the main movers of medicalization were said to be physicians, who had the power of definition in regard to health and illness. Conrad (2005) described how the movers of medicalization have shifted from being mainly physicians to including biotechnologies and consumerism, both of which can be related to the pharmaceutical industry. As such, medicalization seems to begin to overlap with disease mongering when the shifting movers of medicalization, with the pharmaceutical industry newly implicated as a main mover of medicalization, are taken into account (Conard, 2005). DTC drug ads have been argued to disease monger, and, as such, to medicalize a broadening range of human experiences (Arney, & Menjivar, 2014; Healy, 2006; Moynihan et al., 2002).

The women may have been mobilizing academic discourses related to disease mongering and medicalization through the women's own academic engagement. For example, several of the women from the focus groups informally communicated that they were affiliated with a university in some capacity; there were individuals who indicated that they were/are students,

and/or work(ed) for the university. As such, participation within academia might influence the discourses the women are able to mobilize in their interactions with the ads. Access to these discourses may have promoted attention to presentations of disease mongering and medicalization in the ads, shaping what aspects of the ads got talked about.

Though medicalization and disease mongering have been widely discussed within academia, they also seem to have penetrated popular discourse (Moynihan et al., 2008). For example it has been noted that,

> at a consumer level, Health Action International (http://haiweb.org) – the activist group working for a more rational use of medicines globally – has for a long time been concerned about what it has described as the blurring of boundaries between ordinary life and medical illness in order to expand markets for drugs and other technologies. (Moynihan & Henry, 2006 as cited in Wolfe, 2006, p. 3)

Similarly, Moynihan et al., (2008) has cited cases in which public media have troubled the medicalization of experience. For example, there have been news articles in the *Wall Street Journal* titled "How Glaxo Marketed a Malady to Sell a Drug" (Whalen, 2006 October 25, as cited in Moynihan et al., 2008, p. 0685) and in the *New York Times* titled "Drug Approved. Is Disease Real?" (Brenson, 2008 January 14, as cited in Moynihan et al., 2008, p. 0685). Further, Moynihan et al., (2008) have also argued that

> there are reliable signs that disease mongering is now part of the global health debate. Within the media, consumer movements, and the professional and research communities, increasing numbers of people are formulating ways to confront the problem, in some cases forcing the pharmaceutical industry to respond. (p. 0684)

These are just a few examples where academic discourses about disease mongering and medicalization might have been noted by some scholars as meeting and being mobilized within public discourse. As such, the women who participated in the present study might be mobilizing discourses related to medicalization and disease mongering that have been circulating within not only academia (Conrad, 1992, 2005; Moynihan et al., 2008; Moynihan et al., 2002), but have also the public (Moynihan et al., 2008; Moynihan & Henry, 2006 as cited in Wolfe, 2006).

Through mobilizing these various discourses, the women position the advertisements as presenting not particularly helpful ways of knowing normal; though the medicalization and disease mongering is on occasion positioned as potentially useful from a profit perspective, the

ads are problematized by the women in terms of being helpful from a public perspective. As such, the women seem to mobilize critical discourse surrounding medicalization and disease mongering as a means to resist them. Resistance of this medicalization and disease mongering takes the particular form of an undermining of the ads' claims to normal and a reclaiming of the experiences in the ads as normal. Looking more broadly, medicalization has been positioned as a potential form of social control, due to the power in defining deviance and normalcy (Conrad, 1992). This resistance to the ads' medicalizing claims might also work as a resistance to this broadening of social control by the pharmaceutical industry.

4.3 Reclaiming Depression

The reclaiming of depression within the focus groups highlights a potential threat to depression posed by the claims of the ads, as well as risk for the women in interacting with the claims. Reflecting on the women's use of language in interacting with the ads, as well as arguments in the literature related to medicalization and disease mongering in regard to DTC drug ads, the women's attempts at reclamation of depression might reveal more than a simple 'disagreement' with the ads' presentation(s). Specifically, there seems to be a threat to depression that risks further stigmatization and de-legitimization of depression. In particular, there is evidence of a potential mobilization and intersection of currently circulating discourses related to medicalization and disease mongering, and stigma of mental health.

First, the reclaiming of depression might relate to medicalization and disease mongering but with a different focus than much of the current academic literature. Much of the current literature on medicalization and disease mongering has focused on how these phenomena impact the people who have experiences that newly become medicalized (e.g., contributes toward inappropriate treatment; e.g. Conrad, 1992, 2005; Lexchin, 2006; Mintzes, 2006a; Tiefer, 2006). Little focus has been on how this medicalization and disease mongering might impact mental illness itself, and how mental illness is framed.

That the women specifically position these ads as normalizing and minimizing depression, particularly when reflecting on arguments that the ads themselves disease monger and medicalize experience (Arney, & Menjivar, 2014; Conrad, 1992, 2005; Mintzes, 2006a; Moynihan et al., 2008; Moynihan et al., 2002), is significant. More specifically, the women's talk evidences how this medicalization and disease mongering might threaten the legitimacy of depression through a combined linguistic normalization and minimization. This notion of a threat

to depression is clarified and poignantly reflected in the following quote from the popular memoire of a woman's experience with depression and treatment, *Prozac Nation* (Wurtzel, 1995). In the epilogue of the memoire, when discussing changes to diagnosis and treatment of depression, the author stated,

> I can't get away from some sense that after years of trying to get people to take depression seriously – of saying, I have a *disease*, I *need* help – now it has gone beyond the point of recognition as a real problem to become something that appears totally trivial. […] Every so often, I find myself with the urge to make sure people know that I am not just on Prozac but on lithium too, that I am a real sicko, a depressive of a much higher order than all these happy-pill poppers with their low-level sorrow. Or else I feel compelled to remind people that I've been on Prozac since the F.D.A. first approved it, that I've been taking it longer than anyone else on earth, save for a few laboratory rats in cages, trapped but happy. (Wurtzel, 1995, pp. 341-342)

Through reflecting on this quote, there is a threat of de-legitimization of depression, contributing toward a reclaiming and defence of depression as severe and serious, as depression becomes more encompassing and treatment more easily accessed – there seems to be an indication of a trivialization or de-legitimization of depression as the diagnosis becomes more common and treatment more easily accessed (Wurtzel, 1995).

Within the focus groups, the women similarly re-position depression as severe, serious, and uncommon, in the face of a presentation that they imply downplays, trivializes, and normalizes depression. Further, these notions of ease of access and broadening diagnosis (Wurtzel, 1995), as well as trivialization and minimization of depression, can be at least tangentially linked to discussions and debate surrounding medicalization and disease mongering. Specifically, medicalization and disease mongering by definition expand the scope of treatable illness, encouraging more experience to be considered within the domain of medical expertise and treatment (Arney, & Menjivar, 2014; Conrad, 1992, 2005; Mintzes, 2006a; Moynihan et al., 2008; Moynihan et al., 2002). This expansion might threaten depression and, further, as with reclaiming normal, through reclaiming depression the women might be mobilizing discussion and debate currently circulating within academia and popular media in regard to medicalization and disease mongering (Arney, & Menjivar, 2014; Conrad, 1992, 2005; Mintzes, 2006a; Moynihan et al., 2008; Moynihan et al., 2002). More specifically, the women might be resisting

medicalization and disease mongering discourses in the ads through problematizing their implications – the expanding of diagnosis into the domain of more common experiences of distress, risking normalizing and trivializing depression.

One way in which the ads might threaten to delegitimize depression might be through the risk of promoting/supporting stigmatizing discourses of mental illness. For example, some research has specifically identified that DTC drug ads use the 'shame and blame technique,' in which they position having an illness and not meeting role expectations as shameful, and the individual as to blame for not having gotten treatment (Chananie, 2005). Looking at stigmatizing discourses of mental illness in general, the positioning of mental illness as within the control of those with the illness experiences, as well as the positioning of those with a mental illness as somehow to blame or responsible for their illness, has been associated with greater public stigmatization of mental illness (Corrigan et al., 2000; Feldman & Crandall, 2007). More specifically, the public has communicated sentiments of greater preferred social distance from people with a mental illness based on the above mentioned positioning of mental illness (Corrigan et al., 2000; Feldman & Crandall, 2007). The sentiment that people with a mental illness should just be able to 'just get over it' might be linked to notions of blame/responsibility and control – if it is said that those with a mental illness should just be able to 'get over it,' this implies that they are in control of the experience, and to blame or responsible for not getting well. As noted, it has been argued that DTC drug ads do promote the positioning of the individual as blameworthy, such as for not getting treatment (Chananie, 2005), and therefore might, in this way, promote stigmatization of depression.

There is evidence of a potential link to medicalization and disease mongering when considering Gergel's (2014) discussion of likeness-based stigma. Specifically he noted that, through promoting more general association of the public's experiences with experiences related to mental illness, as implied by disease mongering, this association might bolster the talk that those with a mental illness should be able to get well without treatment. For example, he stated that likeness-based stigmatizing discourse might promote the position that those with a mental illness are "fundamentally the same [as the public], but lazy, weak or incapable, and therefore responsible and blameworthy for their condition: '[mental illness] results from personality weakness or character flaw, and people could snap out if they tried harder" (p. 150).

As mentioned, the women discursively distance depression from normal and descriptively milder experiences, and reclaim or reposition depression as severe, serious, and uncommon. As such, there is a potential resistance, on the part of the women, to this stigmatizing talk of mental illness in general and depression specifically. More specifically, the medicalization and disease mongering in the ads might threaten the legitimacy of depression by associating it with milder or more common experience.

Further highlighting a potential link to stigma discourses, the women's discursive resistance to the risk of minimization and normalization of depression is in line with currently circulating anti-stigma talk related to mental illness (Bell Canada, 2015; Canadian Mental Health Association, 2015; Healthy Minds Canada, n.d.a, b, c; Shatter the Stigma Mend the Mind, 2014; Untitled online image 1-7). More specifically, there seems to be a discursive trend towards emphasis on the positioning of mental illness as something that is severe and serious, and avoidance of the positioning of mental illness as trivial or minimal (e.g, Bell Canada, 2015; Canadian Mental Health Association, 2015; Healthy Minds Canada, n.d.a, b, c; Shatter the Stigma Mend the Mind, 2014; Untitled online image 1-7). There is also evidence of circulating discussion promoting a self-regulation and monitoring (of self and other) of language used when talking about mental illness (e.g. Bell Canada, 2015; Canadian Mental Health Association, 2015). As such, there is evidence of a reaction against the stigmatizing discourses related to mental illness (Bell Canada, 2015; Canadian Mental Health Association, 2015; Healthy Minds Canada, n.d.a, b, c; Shatter the Stigma Mend the Mind, 2014; Untitled online image 1-7); the women seem to mobilize this anti-stigma talk when interacting with the advertisements. Just to get a sense of this anti-stigma talk related to mental illness, included are a few examples from online anti-stigma campaigns, as well as from general online searches related to anti-stigma images/posters and slogans (see Appendix J for further examples and resources).

One example of this anti-stigma discourse can be found on the *Shatter the stigma, mend the minds* (2014) campaign website. On their website they have a section specifically devoted to debunking 'myths' related to mental illness. In this section they state, "Myth #5: Depression is a character flaw and people should just 'snap out of it'. Reality: Research shows that depression has nothing to do with being lazy or weak. It results from changes in brain chemistry or brain function. Therapy and/or medication help people to recover" (Shatter the Stigma Mend the Mind, 2014). Note here a resistance to the positioning of depression as in the control of those with

depression, and a direct link to the stigmatizing positioning of mental illness (countering) as something one should be able to take agency for and get well from. Another example of talk surrounding anti-stigma of mental illness is the *STOP* campaign of the Canadian Mental Health Association (2015). The association specifically indicates how the public can help stop stigma of mental illness using reference to their 'stop criteria':

> Use the STOP criteria to recognize attitudes and actions that support the stigma of mental health conditions. It's easy, just ask yourself if what you hear: […]
>
> > **T**rivializes or belittles people with mental health conditions and/or the condition itself?
> >
> > **O**ffends people with mental health conditions by insulting them? […]
>
> If you see something in the media which does not pass the STOP criteria, speak up! Call or write to the writer or publisher of the newspaper, magazine or book; the radio, TV or movie producer; or the advertiser who used words which add to the misunderstanding of mental illness. Help them realize how their words affect people with mental health conditions.
>
> Start with yourself. Be thoughtful about your own choice of words. Use accurate and sensitive words when talking about people with mental health conditions. (Canadian Mental Health Association, 2015)

Here there is an emphasis being placed on specifically avoiding trivialization of mental illness, and a specific and direct encouragement to mobilize this anti-stigma talk and circulate it through self and other regulation. Further, in the *Let's Talk* campaign by Bell Canada (2015), a section on the website indicates five ways to combat stigma of mental illness. One of these, which again has a focus on avoiding trivialization of mental illness, states,

> Talking is the first step towards meaningful change and building greater awareness, acceptance, and action. […] LISTEN AND ASK [:] Sometimes it's best to just listen. HOW YOU CAN HELP[:] Don't trivialize someone's illness. Instead, say: "I'm sorry to hear that, it must be a difficult time. Is there anything I can do to help?" (Bell Canada, 2015)

Again there is an emphasis being placed on being vigilant in terms of language regulation in relation to mental illness, including resisting stigmatizing talk discussed earlier.

Further, Google image searches using terms related to anti-stigma of mental illness (e.g., 'anti-stigma campaign for mental illness') return similar examples of the positioning of mental illness as noted above (Healthy Minds Canada, n.d.b, c; Untitled online image 1-7). For example, some images have slogans such as "yes, I have depression. No, I can't just 'get over it'," (Untitled online image 7) "A lot of people get cancer because they just can't deal with reality. Imagine if we treated everyone like we treat those living with mental illness," (Healthy Minds Canada, n.d.b) "Heart disease. Just another excuse for lazy people not to work. Imagine if we treated everyone like we treat those living with mental illness," (Healthy Minds Canada, n.d.c) "you'd never say, 'it's just cancer, get over it," (Untitled online image 3) and "telling a depressed person to be happy is like telling a cancer pat[i]ent to cure themselves…" (Untitled online image 1). Again, the emphasis is placed on mental illness as severe and serious, particularly through association with physical illnesses, and as something that one cannot 'just get over'. In essence, the above anti-stigma discussions seemed to have been countering the potential trivialization of mental illness (Bell Canada, 2015; Canadian Mental Health Association, 2015; Healthy Minds Canada, n.d.a, b, c; Shatter the Stigma Mend the Mind, 2014; Untitled online image 1-7), as did the women in the focus groups.

The stigmatizing talk of mental illness has been noted as being associated with various negative outcomes in terms of the health and well-being of those with a mental illness (Feldman & Crandall, 2007; Glozier, 1998; Rüsch et al., 2005; Sirey et al., 2005). For example, when stigmatization surrounding mental illness is noted as low, those with a mental illness are more likely to adhere to treatment (Sirey et al., 2005). Through impacting health behaviours, this discourse of mental illness might impact the well-being of those with a mental illness. Further, stigma has been noted as contributing toward greater preferred social distance from those with a mental illness (Feldman & Crandall, 2007; Norman et al., 2012; van't Veer, Kraan, Drosseart, & Modde, 2006), which might contribute to experiences of social isolation. Finally, stigma has also been related to discrimination within the workplace, contributing toward difficulty for those with a mental illness to get a job – they were found to be less likely to get a position than someone with diabetes, despite equal qualifications (Glozier, 1998). As such, stigmatizing talk related to mental illness might have consequences for everyday interactions of people with a mental illness and relate to health and well-being.

Interestingly, the reclaiming of depression as severe, serious, and uncommon when interacting with the advertisements by the women in the focus groups happens despite the argument within academia that these types of ads present a distinctly individualized and biomedical model of depression (Grow, Park, & Han, 2006; Kleinman & Cohen, 1991; Rubin, 2004). Some research has argued that a biomedical model of mental illness might help reduce stigma by reducing perceptions of blame (Deacon & Baird, 2009; Lebowitz, Ahn, & Nolen-Hoeksema, 2013). On the other hand, these ways of knowing mental illness have been noted as contributing toward perceived dangerousness, as well as pessimism of prognosis/recovery, which have been related to increased stigma (Angermeyer, Holzinger, Carta, & Schomerus, 2011; Deacon & Baird, 2009; Lebowitz et al., 2013). There has also been research that has noted, in general, that DTC drug ads for mental illness are stigmatizing (Corrigan et al., 2014).

Tying this discussion back to the specific context of the focus groups, the women seem to mobilize this anti-stigma talk (Bell Canada, 2015; Canadian Mental Health Association, 2015; Healthy Minds Canada, n.d.a, b, c; Shatter the Stigma Mend the Mind, 2014; Untitled online image 1-7) and critical debates surronding medicalization and disease mongering (Arney, & Menjivar, 2014; Conrad, 1992, 2005; Mintzes, 2006a; Moynihan et al., 2008; Moynihan et al., 2002). More specifically, through mobilizing the anti-stigma talk that attempts to counter the positioning of depression as trivial and minimal (Bell Canada, 2015; Canadian Mental Health Association, 2015; Healthy Minds Canada, n.d.a, b, c; Shatter the Stigma Mend the Mind, 2014; Untitled online image 1-7), the women seem to positon the ads as threatening to stigmatize depression, or at least support stigmatizing ways of knowing depression. The ads are positioned as trivializing and minimizing depression. As such, the ads are positioned as not presenting a particularly helpful way of knowing depression, but rather seem to threaten its legitimacy - potentially through medicalization and disease mongering. Further, the women might be mobilizing the anti-stigma talk surrounding personal and individual responsibility in terms of identifying and 'calling out' sources of stigmatizing talk of depression (Bell Canada, 2015; Canadian Mental Health Association, 2015) – this might be reflected in the women's explicit problematization of the presentation of depression within the ads.

4.4 Caution in and Defence of Claims: The Introduction of Ambiguity

The caution that the women demonstrate in engaging with and staking claims to normal and depression seems to complete several actions. On a broad level, the use of systematic

vagueness and the introduction of uncertainty and ambiguity fits with Potter's (1996) notion of defensive rhetoric – it helps the women make their claims to the categories more difficult to undermine. What is most interesting is how this caution might also bring to attention what might be at risk in engaging with and staking claims to normal and depression. Further, it might also reflect the uncertainty surrounding depression and normal that seems to be present at least within academia – there is much debate and disagreement about mental illness (Astbury, 2006; Ingram, Atchley, & Segal, 2011; Lacasse & Leo, 2005; Obeyesekere, 1985; Russell, 1995; Shafter, 1989; Szasz, 1960; Vice, 1989).

First I consider how the caution in engaging with the categories and making claims to them might reveal risk in engaging with notions of depression and normal. The women seem to walk a fine line between reclaiming normal and refuting experiences of depression. For example, one participant said 'don't get me wrong, depression is very real' after reclaiming normal. They also seem to walk a fine line between refuting other experiences of or ways of knowing depression through reclaiming it as severe and serious (e.g., implying that those with milder experiences of depression do not have depression [depression as more severe], or should be able to get well by taking agency). Reflecting on the above discussion of anti-stigma talk (Bell Canada, 2015; Canadian Mental Health Association, 2015; Healthy Minds Canada, n.d.a, b, c; Shatter the Stigma Mend the Mind, 2014; Untitled online image 1-7), it can be noted how there is a risk that the speaker, in engaging with and staking claims to both normal and depression, might be positioned as perpetuating stigma talk of mental illness, and therefore being positioned negatively. For example, the speaker might be positioned as minimizing depression or refuting its existence when reclaiming normal, and she might similarly refute certain forms of depression in repositioning it as severe and serious, and countering the claims of the ads. The potential negative positioning of the speaker, should she be noted as using stigma talk, would also potentially bring into question the participant's claims – it might work to increase the risk of their claims being undermined.

As noted earlier, not only do anti-stigma campaigns emphasise an acknowledgement of mental illness as severe and serious, some also emphasise a hypervigilance in one's own use of language (Bell Canada, 2015; Canadian Mental Health Association, 2015). Responsibility is placed on the individual to not only attend to how others might talk about mental illness, but also how they themselves use language when engaging with the category (Bell Canada, 2015;

Canadian Mental Health Association, 2015). The women's caution in engaging with and staking claims to normal and depression might reflect this talk and promotion of self-regulation and caution in relation to talk of mental illness.

Second, this introduction of systematic vagueness might also reflect uncertainties, as shown in the various disagreements related to mental health and illness that continue to circulate, particularly within academia (Astbury, 2006; Ingram et al., 2011; Lacasse & Leo, 2005; Obeyesekere, 1985; Russell, 1995; Shafter, 1989; Szasz, 1960; Vice, 1989). More specifically, there are various theories of mental illness in general and depression specifically. From biological models, to more cognitive and social models, to some authors having positioned mental illness as a convenient 'myth,' there have been debates about what exactly mental health and illness entails (Astbury, 2006; Ingram et al., 2011; Lacasse & Leo, 2005; Obeyesekere, 1985; Russell, 1995; Shafter, 1989; Szasz, 1960; Vice, 1989). Further, reflecting on the notions of medicalization and disease mongering, the line between mental illness and health can become relatively ambiguous and more fluid than categorical diagnostic distinctions imply (Conrad, 1992, 2005; Healy, 2006; Moynihan et al., 2008; Moynihan et al., 2002). This debate has taken place despite the existence of diagnostic criteria for specific mental illnesses such as the Diagnostic and Statistical Manual (DSM; American Psychological Association, 2014), and the International Classification of Disease (ICD; World Health Organization, 2015). Even these diagnostic manuals themselves are continually changing and being revised, as is evident in there having recently been released a fifth edition of the DSM (American Psychological Association, 2014). There have also been debates about whether a categorical model of mental illness, as has been argued to be reflected in the DSM, is a useful way of conceptualizing mental illness, or whether a more dimensional approach may be more advantageous (Ingram et al., 2011).

Some researchers have even postulated that diagnostic systems themselves may communicate an uncertainty and an ambiguity about the diagnosis of depression (Galasiński, 2008). Focusing on the ICD, Galasiński (2008) discusses how the language used in the presentation of criteria for depression introduces this uncertainty and ambiguity. For example, he notes how the use of such wording as 'should' in regard to some of the criteria for a diagnosis of depression leaves the diagnosis uncertain through positioning the criteria in a less definite way. Galasiński (2008) goes so far as to position the use of 'should' in the context of diagnostic criteria as a form of hedging that weakens the claim. Further, the use of such terms as "abnormal

mood" and "almost every day" (p. 28), as well as the general vagueness surrounding the identification of what is 'normal' for an individual, are noted as introducing ambiguity into diagnostic criteria. Interestingly, Galasiński (2008) states that some of the introduced uncertainties are not present in translations of the ICD (the author made a specific comparison to the Polish translation). This difference between transitions may itself also further demonstrate the uncertainty surrounding depression (e.g., slight inconsistencies between versions intended to be direct translations; Galasiński, 2008), which may influence the discursive certainty surrounding the diagnostic category more generally (e.g., public discourse).

As such, there is much discussion, debate, uncertainty, and fluidity in academia's positioning of mental illness. The caution and tentativeness of the women's talk in regard to depression and normal might reflect this uncertainty and contention about mental health and illness, and, by implication, about what constitutes normal.

4.5 Interesting Absences

Though it is interesting and valuable to note how language is used within the focus groups, it is equally interesting to note how it is not used. Gender does not seem to be a central issue in the women's interactions with the ads. In many cases, the issue of gender emerges mainly when the specific questions related to gender are asked by the coordinator, and references are relatively fleeting. The focus was less on how the ads presented gender, and more on depression and its treatment. As gender does not seem to emerge as prominent in the context of the focus groups, and due to the need to narrow the focus of analysis for the purpose of this paper, gender is not focused on in the present analysis.

Another interesting absence is differences in engagement with the ads based on age. There was an attempt to prompt the participation of women from varying age groups (younger and older women, flexibly defined). The reasoning for this was that there is evidence in the literature that older adults may view DTC drug ads differently than younger adults – more positively – and how women talk about of antidepressant treatment has been noted as potentially varying by age (Morris et al., 1986; Stoppard & Gammell, 2003). Age differences were not particularly prominent in the current analysis. However, the age variation of the women who participated was not large. This lack of variation might partly account for why age differences were not very prominent. As such, as with gender, due to constraints of this project less focus was placed on age variation.

4.6 Overall Conclusions

First, as noted earlier, there needs to be caution in positioning consumers as passive 'victims' to advertisements. Rather, the complex way the consumer interacts with ads and makes meaning of them using various available discourses should be taken into account. Not acknowledging the active negotiation and mobilization of talk in interacting with the ads would miss the nuances in interactions and risks oversimplifying engagement with the ads.

As such, rather than simply relying on the quantification of the impact of DTC drug ads, how meaning of them is made should also be considered in debates concerning the ads. There will likely continue to be discussion and debate about what is 'actually' presented in the advertisements, including their accuracy and whether they provide unbiased and educational information. But the content itself is likely less relevant than how it is actually engaged with and mobilized. Through asking whether the advertisements present a 'useful' way of knowing and for whom this way of knowing might be useful, rather than assuming some notion of absolute truthfulness or accuracy, a more complex debate might emerge. With respect to disease mongering, it has been postulated that these advertisements present a useful way of knowing for the pharmaceutical companies, as they allow expanding of markets and therefore of profits (Arney, & Menjivar, 2014; Mintzes, 2006a; Moynihan et al., 2008; Moynihan et al., 2002). Reflecting on the focus groups, it is evident that the ads do not seem to present a particularly useful way of knowing normal and depression to the women. Specifically, the ads threaten not only normal, which might have been hypothesised based on circulating discussions of disease mongering (e.g. Arney, & Menjivar, 2014; Mintzes, 2006a; Moynihan et al., 2008; Moynihan et al., 2002), but also depression. Reflecting on the discussion above in relation to stigma and anti-stigma campaigns, the ways the ads are taken up seem to indicate that the ads risk supporting stigmatizing talk surrounding mental illness, which trivialize, downplay, and marginalize the experience (Bell Canada, 2015; Canadian Mental Health Association, 2015; Healthy Minds Canada, n.d.a, b, c; Shatter the Stigma Mend the Mind, 2014; Untitled online image 1-7). Further research is needed to explore how medicalization and disease mongering might contribute to stigma talk of mental illness.

There have been general explorations of the impacts and very broad evaluations of these types of advertisements (An, 2008; Bell et al., 2010; Block, 2007; Coney, 2002; Gardner, 2003; Harker & Harker, 2007; Kleinman, & Cohen, 1991; Lacasse, 2005; Mackert & Love, 2011;

Mintzes, 2006b; Rubin, 2004; Zetterqvist & Mulinari, 2013), but few scholars have actually looked at or accounted for how the public makes meaning of the messages in the ads when interacting with them, and how they mobilize various discourses when doing so. Based on the focus groups, the ads threaten normal and depression in various ways, which is evidenced in the women's complex mobilization of various available discourses or ways of talking. Though there has been discussion about how these ads might not be helpful due to being a 'threat to normal' – see discussion of medicalization and disease mongering (e.g., Arney, & Menjivar, 2014; Conard, 1992, 2005; Mintzes, 2006a; Moynihan et al., 2008; Moynihan et al., 2002), the current research brings to attention that these ads might also threaten depression through undermining claims to depression as severe, serious, and uncommon, which might be mobilized to legitimize depression (see Wurtzel, 1995 for examples of the use of severity and seriousness to legitimize depression). Through undermining these claims, the ads might threaten to delegitimize depression and support or partly mobilize stigma talk of mental illness. The issue here is not the intentionality behind the ads, of whether they are truthful, but rather whether they are useful. Based on how the women from the focus groups interact with the ads, the ads do not seem to present particularly helpful ways of knowing.

4.7 Significance

The significance in making the distinction between reclaiming normal and reclaiming depression should be noted. Though it could be argued that the reclamation of normal might be implied in the reclamation of depression, the distinction is important to make for several reasons. First, depression was not only distanced from 'normal', but also from alternative experiences (some of which have varying degrees of pathological association). Further, in the reclamation of normal, the category is not only distanced from depression specifically, but from pathologization more generally. As such, though there might be overlap between these two categories of analysis, the similarities alone do not encompass the nuances of both categories of analysis. Second, the categories of analysis evidence two distinct but related threats – to normal and to depression – in interacting with the ads. The participants positioned as important both the need to reinforce depression as a category, as well as normal, in interacting with the ads. Teasing apart these categories allows for a highlighting of both threats, which is relevant when considering the significance of this research and the way it adds to current literature related to DTC drug ads. For example, the analytic distinction made between these categories highlights how, when

considering normalization and medicalization within DTC drug ads, it should be consider that there may not only be a threat to normal (being pathologized), but also to depression (being trivialized). Much research that has looked at medicalization and normalization within DTC drug ads seems to have focused on the threat to normal. As such, the women's interactions with the ads highlight the complexity of how the messages in the ads are interacted with and discourses mobilized. As such, making the distinction between reclaiming normal and reclaiming depression is significant in the way it allows for a more complex and nuanced way of understanding how the women interact with the advertisements and mobilize discourses, including those presented within the ads.

The significance of the distinction made between the reclamation of normal and reclamation of depression relates to the overall significance of the current research project. More specifically, highlighted is the need for a consideration of not only how these ads might threaten normal, but also depression, when discussing the issue of medicalization within the ads in the context of policy debates. As such, this research highlights an area relatively neglected by current research on DTC antidepressant drug ads that might require further consideration, such as in policy debates – how they might threaten depression. If the ads are taken up as positioning depression as not severe or serious, it might undermine available discourses for justification of treatment – which might risk negatively impacting treatment seeking. Further, as noted earlier, if the ads are positioned as trivializing depression, it might support stigma discourses, which have consequences for the health and well-being of those with a mental illness (Feldman & Crandall, 2007; Glozier, 1998; Rüsch et al., 2005; Sirey et al., 2005).

Looking more broadly, this research may provide valuable information as to how people mobilize health information presented in DTC antidepressant advertisements. For example, with an understanding that the ads might threaten both normal and depression, it might be possible to identify potential barriers to the communication of health information – through these threats, potentially useful information within the ads, such as that which may promote help seeking, might be undermined. This point is arguably not only relevant to DTC antidepressant drug advertisements, but is also potentially relevant to other forms of health information communication.

This research is also significant in the way that it allows for a more nuanced look at how people interact with these types of ads. More specifically, rather than assuming that because

certain messages and discourses related to health are presented within the advertisements they are passively consumed, research that looks at meaning making allows for a more nuanced understanding of the potential impact of these ads. As such, this research is significant in the way it allows for a more complex debate surrounding the impact of these ads and how health information is interacted with.

4.8 Future Directions

Acknowledging that all research takes place within a specific context, this research is no exception. This context is acknowledged as shaping the nature of the research findings and providing potentially valuable areas for exploration in future research.

First, this study includes only women as participants. As mentioned, women are diagnosed with depression, and treated with antidepressants more frequently than men, and are considered a target population of much DTC drug advertising (Brownfield et al., 2013; Kleinman & Cohen, 1991; Pratt et al., 2011; WHO, 2012). It would be valuable to undertake similar research to explore how men might interact with the advertisements. For example, do they critically engage with the ads in a similar fashion as the women? Do they access similar discourses? Do they position depression in a similar way?

Second, though there was an attempt to explore how 'older' and 'younger' women interact with the advertisements, most of the women who participated in this project were of a similar and relatively young age group. As mentioned, research has identified that how the public evaluates DTC drug advertising in general varies by demographic variables such as age (Huh et al., 2004; Morris et al., 1986). Perhaps if there was a greater variation in age, differences in interaction might have become evident. As such, future research might benefit from attempting to more directly recruit participants of a larger age range if difference in interaction by age is of particular interest.

Third, three specific DTC drug antidepressant ads were used in the focus groups. The choice of ads was based largely on availability/accessibility. It would be interesting to explore if women interact with other antidepressant ads in a similar fashion. Further, there are also other types of ads related to health and illness, such as disease awareness ads (Mintzes, 2006b). It has been argued that unbranded ads have similar implicit goals as DTC drug ads – to sell more product (Mintzes, 2006a). Do women interact with advertisements that do not directly present a treatment in the same way as with ads that specifically reference antidepressant treatment?

Further, some research has identified that how people evaluate DTC drug ads depends on the medium through which the ads are communicated (Huh et al., 2004). Do women interact with advertisements from other mediums in the same way as with TV ads?

Further, it might be valuable to undertake a similar project in which information related to the participants' experience(s) with depression is also collected and considered. The reasoning for this is that people might differently interact with claims to depression depending on their experience with depression and treatment; there is evidence that how people are impacted by the ads might depend on their experience with depression (An et al., 2009). A valuable question for future research might be, do women with varying levels of experience with depression access similar discourses, and use similar rhetorical moves when interacting with these types of ads? Do they problematize the same aspects of the ads?

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APPENDIX A

ADVERTISEMENTS FOR FOCUS GROUPS

Advertisements option 1:

- Title: Depression Hurts. Cymbalta Can Help
- Product name/brand: Cymbalta
- Link: http://www.ispot.tv/ad/7V1E/cymbalta-depression-symptoms

Advertisements option 2:

- Title: Zoloft commercial
- Product name/brand: Zoloft
- Link: http://www.youtube.com/watch?v=6vfSFXKlnO0

Advertisements option 3:

- Title: Pristiq Commercial #2
- Product name/brand: Pristiq
- Link: http://www.youtube.com/watch?v=uVNZ8ZBP5gY

APPENDIX B

FOCUS GROUP GUIDE

Preliminary questions:

- Has anyone here seen an antidepressant advertisement? Could you please describe it to me [can be general, including impressions of it]?

Impression of the ads:

Show first advertisement

Ad option 1: Cymbalta

- What is your impression of this advertisement?
    - What struck you in particular about the ad?
- In this ad, they show images of individuals with depression before and after treatment. What is your reaction to the depiction of depression before treatment?
    - What is your sense of the extent to which this depiction of depression fits your overall perception of depression?
    - What is your reaction to the slogan 'depression hurts, but you don't have to'?
        - What is your sense of how antidepressant treatment may impact this 'hurting'?
    - What is your reaction to the depiction of individuals after treatment?
        - To what extent do you agree with the depiction of how antidepressant treatment impacts experiences of depression?
- In this ad, the focus is on the individual depicted as suffering from depression despite seemingly normal or enjoyable lives. What is your reaction to this depiction of depression?
    - To what extent do you agree with this depiction of depression as being experienced despite a 'normal' or enjoyable life?

- Is there anything about this ad that we have not discussed that you would like to talk about?

Show second advertisement

Ad option 2: Zoloft

- What is your impression of this advertisement?
    - What struck you in particular about the ad?
- What is your reaction to the representation of depression in the first part of this video, before the dark rain cloud disappears?
    - To what extent does this representation of depression fit how you perceive depression?
    - What is your reaction to the depicted relationship between depression and the dark cloud?
- To what extent do you find the representation of the character 'after treatment' to be a realistic representation of treatment outcomes when taking an antidepressant?
    - What is your reaction to the depiction of treatment with Zoloft as taking away the 'dark cloud' of depression?
    - To what extent does this depiction of the impact of antidepressant treatment fit your perception of the impact of antidepressant treatment?
- In this ad they say that by 'knowing more about what is wrong you can help make it right'. What is your sense of the extent to which this ad provides information about 'what is wrong' when an individual is experiencing depression? [ad mentions that cause is unknown, but mentions how the drug works]
- Again in this advertisement, like in the previous advertisement, there is the depiction of the individual who is depressed as being depressed despite life 'around' the individual being 'sunny'. What is your reaction to this depiction of depression as being something the individual experiences despite life being relatively 'sunny'?

- Is there anything about this ad that we have not discussed that you would like to talk about?

Show third advertisement

Ad option 3: Pristiq

- What is your impression of this advertisement?
    - What struck you in particular about the ad?
- In this ad, a metaphor of needing to 'wind one's self up' was used to represent living with depression. What is your reaction to this depiction of depression?
    - To what extent does it fit with how you perceive living with depression?
- The ad mentions that Pristique works on two main chemicals, serotonin and norepinephrine. What is your sense of the extent to which the ad adequately explains how these chemicals are related to depression?
    - What is your sense of how these chemicals relate to depression and its treatment?
- Is there anything about this ad that we have not discussed that you would like to talk about?

Ending questions

- What is your overall impression of the depiction of depression in antidepressant ads?
- What is your sense of the extent to which these depictions of depression in antidepressant ads are realistic?
- What is your overall impression of depictions of antidepressant treatment in antidepressant advertisements?
- What is your sense of the extent to which these depictions of antidepressant treatment in antidepressant ads are realistic?
- Is there anything about the specific ads shown or about antidepressant advertisements in general that we have not talked about that you would like to bring up?

APPENDIX C

POSTER ADVERTISEMENT FOR PARTICIPANT RECRUITMENT

Are you a woman over the age of 18?

Come explore the messages in TV ads related to mental health!

If so, I invite you to participate in a focus group study on the topic of the messages in TV advertisements for antidepressant.

Duration: 1-2 hours

Methods: During the focus group, 1-3 TV antidepressant advertisements will be shown, and the group will be invited to discuss the content of these ads.

Compensation: Refreshments will be provided, along with $20 compensation for your time

To learn more, please contact:

Christine Babineau (christine.babineau@usask.ca)

Antidepressant advertisement focus group study	Antidepressant advertisement focus group study	Antidepressant advertisement focus group study	Antidepressant advertisement focus group study	Antidepressant advertisement focus group study	Antidepressant advertisement focus group study	Antidepressant advertisement focus group study	Antidepressant advertisement focus group study	Antidepressant advertisement focus group study	Antidepressant advertisement focus group study	Antidepressant advertisement focus group study	Antidepressant advertisement focus group study

APPENDIX D

DEMOGRAPHIC FORM

Age:

How long have you lived in Saskatoon:

If you have lived in Saskatoon for less than a year, where did you live previously?

Is there anything else you would like to add/like me to know:

APPENDIX E

CONSENT FORM

UNIVERSITY OF SASKATCHEWAN

Participant Consent Form

Project Title: Making meaning of media messages: How women interact with the messages in direct-to-consumer antidepressant advertisements

Researcher(s): Christine Babineau, Graduate student, Department of Psychology, University of Saskatchewan, e-mail: christine.babineau@usask.ca

Supervisor: Dr. Linda McMullen, Department of Psychology, University of Saskatchewan, (306) 966-6666, e-mail: linda.mcmullen@usask.ca, & Dr. Pamela Downe, Department of Archaeology & Anthropology, University of Saskatchewan, (306) 966-1974, e-mail: pamela.downe@usask.ca

Purpose(s) and Objective(s) of the Research: You are invited to participate in a research study titled "Making meaning of media messages: How women interact with the messages in direct-to-consumer antidepressant advertisements". There has been much debate surrounding direct-to-consumer antidepressant advertisements, including their impact on the public, and how they should be regulated. Though there has been research that has explored the potential impact these ads have on the public and how the public views these ads in general, few researchers have explored public perceptions of these ads in an in depth way. The purpose of the current study is to explore women's perceptions of antidepressant advertisements. More specifically, this project looks at how women interact with and evaluate the messages in the advertisements.

Procedures: You are invited to participate in a focus group discussion on the topic of the depiction of depression and antidepressant treatment in antidepressant advertisements. The focus group will be between 1-2 hours in length and will consist of between 4-6 participants. During this focus group, you will be shown between 1-3 televised antidepressant advertisements, and be invited to discuss the depictions of depression and its treatment within these advertisements. These ads will be commercials that denote the name of the medication, as well as the ailment it is intended to treat. Though these types of ads are not permitted in Canada, Mintzes (2006) has noted that there are loopholes in regulations that result in American ads, where the mentioning of drug name and ailment are permitted in ads, can be aired on television in Canada. With your consent the focus group will be audio recorded to facilitate later transcription. If you have any questions at any time regarding the current study, including but not limited to the purpose, procedures, or your participation, do not hesitate to ask.

Funded by: The faculty supervisors' Continuing Research Funds and the student researcher's personal funds; Funding through Tri-Council Grants pending

Potential Risks: When participating in focus groups, there are limits to confidentiality, as well as risks related to negative judgment. For example, in regards to confidentiality, it is possible that other group members may share information discussed within the focus groups with others outside of the focus group context. Similarly, when participating in focus groups there is the risk that individuals may be negatively judged by other participants, such as due to discrepancies in opinions. To attempt to mediate these risks, before commencing the focus group, we will briefly discuss various rules and guidelines for participation within the focus group. This will include an emphasis on keeping information discussed in the focus group, including information related to who participated, confidential. It will also include an emphasis on being respectful to others within the focus group, regardless of whether you totally agree with other participants. Please respect the confidentiality of the other members of the group by not disclosing the contents of this discussion outside the group, and be aware that others may not respect your confidentiality. Further, if at any point a question or discussion makes you feel uncomfortable, you can choose

not to answer that question or participate in the specific discussion without any penalty. You may also discontinue participation at any time without explanation or penalty. When participation has been completed or terminated, you will be given a sheet that provides a more in depth explanation of the topic of study and given the chance to ask further questions.

Potential Benefits:

- You may receive no personal benefits from participation in the study.
- The current research will fill a gap in knowledge surrounding perceptions of and interactions with direct-to-consumer antidepressant advertisements.
- The results of this study may also be able to inform future polity related to the regulation of direst-to-consumer drug advertisements.

Compensation: For your time, you will be provided $20 in compensation. This compensation will be provided at the research site. Should you decide to withdraw from participation, compensation will still be provided.

Confidentiality:

- Pseudonyms will be used in transcription of the data to conceal the identity of participants. Further, during transcription any identifying formation, such as the names of people or places, will be removed. Though the data will be used for the basis of a research paper and the results may be disseminated in the form of presentations or publications, at no point will participants be identified. Only the researcher and the supervisors of the current project will have access to the consent forms, and data collected from focus groups.
- **Storage of Data:**
    - Your datum will be temporarily stored on an audio recording device, which will be kept with the researcher at all times. Shortly after data collection, the audio file will be transferred to the student researcher's and faculty supervisors' password

protected computers. At that time audio files will be permanently deleted from the audio recording device.

- Transcripts will be made from the saved audio files using a word processing program and will be saved on the student researcher's and faculty supervisors' password protected computers. Should the transcripts be printed, the transcripts will be kept in the student researcher's possession at all times. When not in use, the transcripts will be stored in a locked cabinet on the University of Saskatchewan campus or in a locked cabinet at the student researcher's home. Faculty supervisors will also have access to printed copies of transcripts, which will be stored in locked cabinets in their offices on the University of Saskatchewan campus. Once the printed transcripts are no longer needed, they will be shredded and destroyed beyond recovery.
- Your consent form, demographic questionnaire information and any notes taken during the focus group will be stored in a locked cabinet in the office of one of the researcher's faculty supervisors, separate from focus group data.
- Data will be kept for a minimum of five years following the completion of the student researcher's Masters of Arts program.

Right to Withdraw:

- Participation is voluntary, and you are free to withdraw from the focus group at any time and that this withdrawal will not affect your academic/employment status, and/or access to, or continuation of, services. Further, you can answer only those questions that you are comfortable with.
- Should you wish to withdraw, your datum will be removed from data collection and destroyed completely. Please understand that if you withdraw from this study, it may not be possible to remove your data from the discussion given that the focus group is a group conversation, where each participant contributes to a contextual whole.
- Your right to withdraw data from the study will apply until December 2014, upon which date pooling of data may have already occurred and your datum may no longer be able to be separated from the data set. After this date, it is also possible that some form of

research dissemination will have already occurred and it may not be possible to withdraw your datum.

Follow up:

- To obtain results from the study, please feel free to contact either the student researcher or her faculty supervisors using the contact information provided above.

Questions or Concerns:

- Contact the researcher using the information at the top of page 1;
- This research project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Consent:

Your signature below indicates that you have read and understand the description provided;

I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

_____	_____	_____
Name of Participant	*Signature*	*Date*

_____ _____

Researcher's Signature *Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

APPENDIX F

ETHICS APPROVAL

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board

Certificate of Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	BEH#
Linda McMullen	Psychology	14-124

INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED
University of Saskatchewan

SUB-INVESTIGATOR(S)
Pamela J. Downe

STUDENT RESEARCHER(S)
Christine Babineau

FUNDER(S)
CANADIAN INSTITUTES OF HEALTH RESEARCH (CIHR)

TITLE
Meaning Making of Media Messages: How Women Interact with the Messages in Direct-to-Consumer Antidepressant Advertisements

ORIGINAL REVIEW DATE	APPROVAL ON	APPROVAL OF:	EXPIRY DATE
14-Apr-2014	21-Apr-2014	Application for Behavioural Research Ethics Review Recruitment Poster Participant Consent Form Demographic Form Focus Group Guide	20-Apr-2015

Full Board Meeting ☐ Delegated Review ☒

CERTIFICATION
The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: *http://www.usask.ca/research/ethics_review/*

Beth Bilson, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to:

Research Ethics Office
University of Saskatchewan
Box 5000 RPO University, 1602-110 Gymnasium Place
Saskatoon SK S7N 4J8
Telephone: (306) 966-2975 Fax. (306) 966-2069

APPENDIX G

ETHICS RENEWAL

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Re-Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	Beh #
Linda McMullen	Psychology	14-124

INSTITUTION (S) WHERE RESEARCH WILL BE CARRIED OUT

University of Saskatchewan
Saskatoon SK

SUB-INVESTIGATOR(S)

Pamela J. Downe

STUDENT RESEARCHER(S)

Christine Babineau

FUNDER(S)

CANADIAN INSTITUTES OF HEALTH RESEARCH (CIHR)

TITLE:

Meaning Making of Media Messages: How Women Interact with the Messages in Direct-to-Consumer Antidepressant Advertisements

RE-APPROVED ON	EXPIRY DATE
25-Mar-2015	24-Mar-2016

Full Board Meeting

Delegated Review ✔

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

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Vivian Ramsden, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to

Research Ethics Office
University of Saskatchewan
Box 5000 RPO University, 1607 - 110 Gymnasium Place
Saskatoon, SK S7N 4J8
Phone: (306) 966-2975 Fax: (306) 966-2069

APPENDIX H

RECIEPT FOR PARTICIPANT COMPENSATION

Making meaning of media messages: How women interact with the messages in direct-to-consumer antidepressant advertisements

Name: _____

Address: _____

I confirm that I received an honorarium of _____ to participate in the above named research project being conducted by Christine Babineau, University of Saskatchewan.

_____ _____

Signature Date

Making meaning of media messages: How women interact with the messages in direct-to-consumer antidepressant advertisements

Name: _____

Address: _____

I confirm that I received an honorarium of _____ to participate in the above named research project being conducted by Christine Babineau, University of Saskatchewan.

_____ _____

Signature Date

APPENDIX I

TRANSCRIPT NOTATION

(Adapted from Lafrance, 2009)

Rather than using pseudonyms, numbers are used to reference participants (e.g., 1(22):). The first number indicates a number assigned to the participant within the group and the second number refers to the participant's age.

The initial 'C' (e.g., C:) is used to refer to the group coordinator's speech (Christine).

Each excerpt is followed by a number in square brackets, which refers to the group number.

An equal sign at the end of a speaker's utterance and at the start of the next utterance indicates the absence of a discernible gap.
e.g., ML: Where was=
= we were talking about

Three periods indicate a discernible pause. More periods prolong the pause.
e.g., that's one of the things that … that is … … … hardest (p. 206)

Two periods were also used to differentiate shorter pauses.

A dash shows a sharp cutoff of speech.
e.g., I thought we would go bu-

A colon indicates an extension of the sound or syllable it follows. More colons prolong the scratch.
e.g., I'm so:: sorry. Re::::lly I am

Bold font indicates that words are uttered with added emphasis.
e.g., and I couldn't believe he just **stood** there

> A series of three periods enclosed within square brackets […] indicates that material has been left out of the excerpt.
>
> Square brackets also mark overlap between utterances, distinguished by the text within them breaking onto a new line.
> e.g., ML: What do you [remember
> I remember] thinking that (pp. 206-207)

When another speaker spoke or made a non-speech sound while another speaker continued to talk (they did not seem to end their 'turn'), the interjection was placed in square brackets.
e.g., 1(22): this participant is talking [C: yeah] and continues talking

Single brackets, were used to indicate "transcriber's description of non-speech sounds or the other features of the talk or scene [including gestures and audible inhales and exhales]" (p. 207).
e.g., (laughing)

When the non-speech sounds were not made by the current speaker, square brackets were used
e.g., 1(22): this speaker is speaking [general laughing] and continues to speak

> Punctuation marks (e.g. .,?!) are used to mark speech delivery rather than grammar. A period indicates a stopping fall in tone; a comma indicates a continuing intonation; a question mark indicates a rising inflection; an exclamation point indicates an animated or emphatic tone (p. 207)

APPENDIX J

ONLINE EXAMPLES OF ANTI-STIGMA TALK

Anti-Stigma Images

Healthy Minds Canada. (n.d.b). *Cancer* [Online image]. Retrieved April 4, 2015 from http://healthymindscanada.ca/campaign/HMC-Cancer.pdf

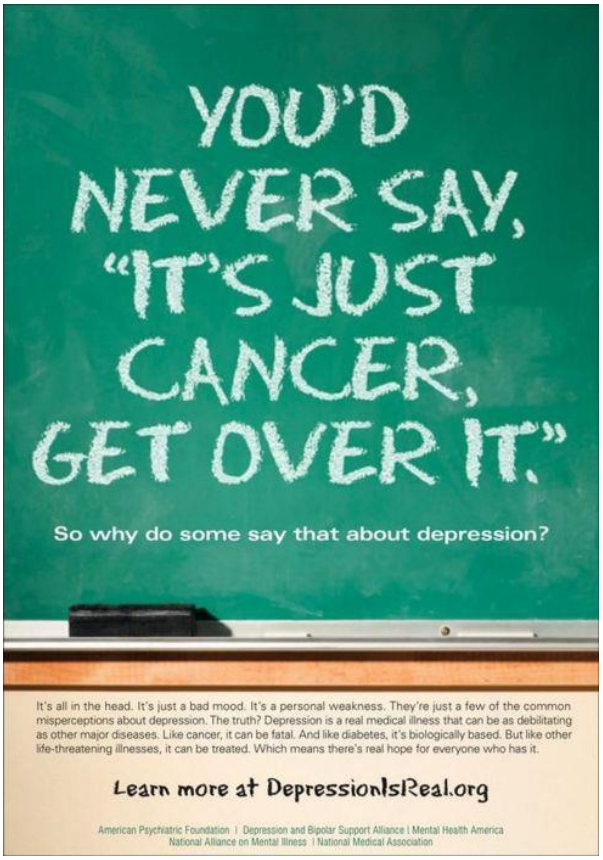
Image 4: Healthy Minds Canada. (n.d.c). *Heart Disease* [Online image]. Retrieved April 4, 2015 from http://healthymindscanada.ca/campaign/HMC-Heart%20Disease.pdf


HEART
DISEASE.
JUST ANOTHER
EXCUSE
FOR LAZY
PEOPLE NOT
TO WORK.
IMAGINE IF WE TREATED EVERYONE LIKE WE
TREAT THOSE LIVING WITH MENTAL ILLNESS.
MENTAL ILLNESS IS REAL. HELP US FIND A CURE.
healthyminds
CANADA

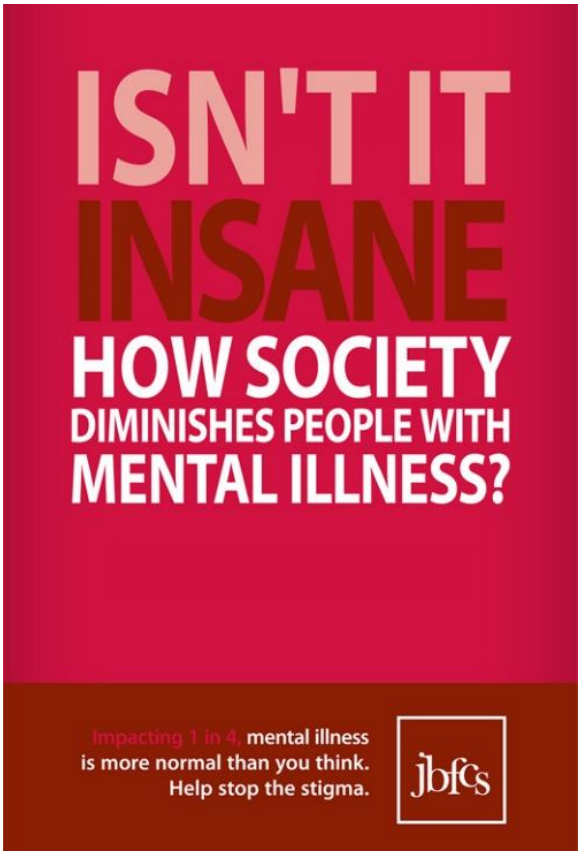
[Untitled online image 1]. Retrieved April 4, 2015 from https://s-media-cache-ak0.pinimg.com/236x/18/61/c0/1861c00ef0270efb4e188bb683974a6b.jpg

[Untitled online image 2]. Retrieved April 4, 2015 from https://altmentalities.files.wordpress.com/2012/09/bringchange2mind-billboard.png

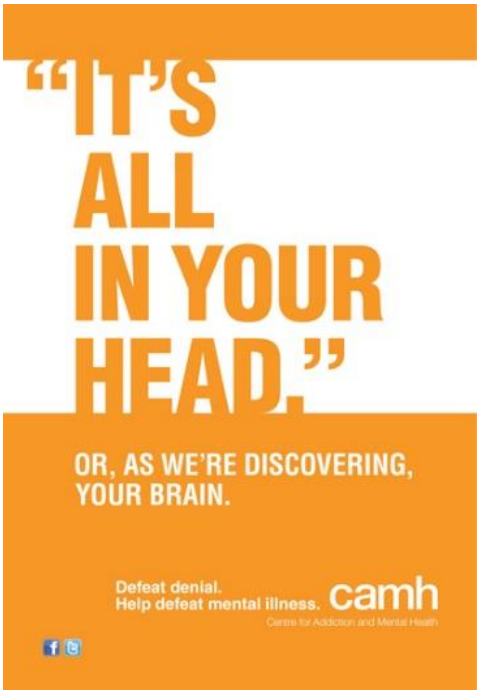
[Untitled online image 3]. Retrieved April 4, 2015 from http://4.bp.blogspot.com/-zlJM_MF2ZRs/T9q7nAJfQ2I/AAAAAAAAABc/UK_1zWc0DhQ/s1600/294557_10150316283737058_209844698_n.jpg



[Untitled online image 4]. Retrieved April 4, 2015 from https://s-media-cache-ak0.pinimg.com/originals/ef/c0/d6/efc0d69a1cb1c434dbd44673c4336c0f.jpg

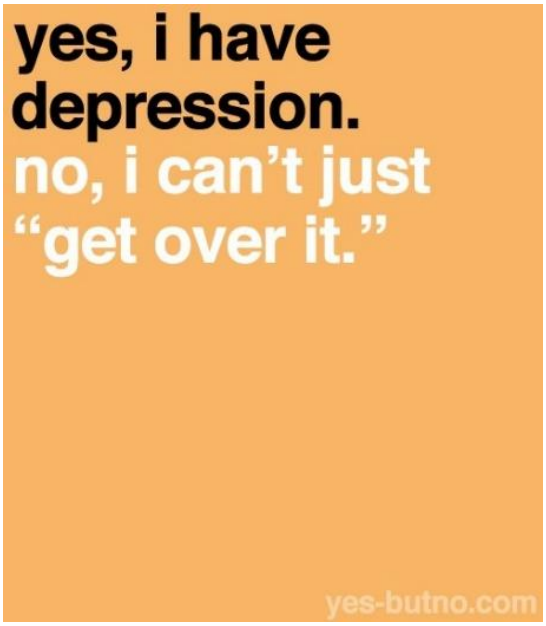


[Untitled online image 5]. Retrieved April 4, 2015 from http://missteentoronto.com/files/2013/07/Itsallinyourhead.jpg



[Untitled online image 6]. Retrieved April 4, 2015 from http://41.media.tumblr.com/8f1390f6f7915105015a38a5f22c475b/tumblr_nd57v35XKN1tg0qpoo4_400.jpg

[Untitled illustration7]. Retrieved April 4, 2015 from http://healthshire.com/wp-content/uploads/2013/03/online-depression-test.jpg



Online Anti-Stigma Websites/Campaigns

Bell Canada. (2015). *5 simple ways to help end the stigma around mental illness*. Retrieved from http://letstalk.bell.ca/en/end-the-stigma/

Canadian Mental Health Association. (2015). *Stigma and discrimination*. Retrieved from http://ontario.cmha.ca/mental-health/mental-health-conditions/stigma-and-discrimination/

Healthy Minds Canada. (n.d.a). *Anti-stigma media campaign*. Retrieved from http://healthymindscanada.ca/anti-stigma-campaign/

Shatter the Stigma Mend the Mind. (2014). *Top 11 myths about mental illness*. Retrieved from http://www.mendthemind.ca/stigma/top-11-myths-about-mental-illness